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ABSTRACT

This journal issue is a contribution to the development of caretaking strategies to help young victims of violence, and is intended to provide support for those who are helping the victims. Four main articles are: (1) "Parenting in Violent Environments" (Joy Osofsky and Beverly Roberson Jackson); (2) "Infants, Toddlers, and Violence: Developing a Community Response" (J. Ronald Lally and Marilyn M. Segal); (3) "The Assessment and Treatment of Infants and Toddlers Exposed to Violence" (Charles H. Zeanah); and (4) "Call for Violence Prevention and Intervention on Behalf of Very Young Children" (The Zero to Three Study Group). These major articles are supplemented by shorter pieces on helping children channel aggression, early intervention, and community policing, as well as brief case studies and vignettes. The report calls for a family-centered approach to addressing trauma and prevention, a realignment of values, and informed comprehensive public policy strategies for reducing violence. A list of 38 organizational resources, along with a list of contributors and the members of the Violence Study Group, are included. Contains 152 references. (MDM)

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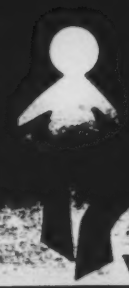

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Caring for Infants and Toddlers in Violent Environments

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To the readers of *Zero to Three:*

This issue of *Zero to Three* is a special one. It contains the complete text of a new publication, *Caring for Infants and Toddlers in Violent Environments: Hurt, Healing, and Hope,* developed by the **ZERO TO THREE** Study Group on Violence, with support from the Ford Foundation.

This publication presents what is known about the impact of early experiences of violence on development. It suggests ways to help children and adults cope successfully with their experience of violence. It describes ways in which community institutions can become safe havens for very young children and their caregivers.

We hope that you will find *Caring for Infants and Toddlers in Violent Environments* useful in your own work. We encourage you to share and discuss it with colleagues, neighbors, advocates, public officals, and your local media. Please use the form on the inside back cover to order additional copies; contact Emily Fenichel if you are interested in community-wide or conference dissemination.

With best wishes for a safe and peaceful new year–

Emily Fenichel and Joy D. Osofsky

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Caring for Infants and Toddlers in Violent Environments: Hurt, Healing, and Hope

JOY D. OSOFSKY and EMILY FENICHEL, *editors*
The **ZERO TO THREE** Study Group on Violence

ZERO TO THREE/National Center for Clinical Infant Programs
Arlington, Virginia

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ZERO TO THREE/National Center for Clinical Infant Programs is the only national non profit organization dedicated solely to improving the chances for healthy physical, cognitive and social development of infants, toddlers, and their families.
Established in 1977, **ZERO TO THREE** is committed to:

- exercising leadership in developing and communicating a national vision of the importance of the first three years of life and of the importance of early intervention and prevention to healthy growth and development;
- focusing attention on the quality of infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships;
- developing a broader understanding of how services for infants, toddlers, and their families are best provided; and
- promoting training in keeping with that understanding.

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We gratefully acknowledge support from the Ford Foundation, from the Violence Study Group of **ZERO TO THREE**/National Center for Clinical Infant Programs, and from the children, parents, and community workers who must live with violence every day and have been willing to share their experiences of hurt, healing, and hope.

INTRODUCTION

Joy D. Osofsky, Ph.D

Violence has saturated our nation. It has reached down to our very youngest children and has even shaken the cradle. Parents are concerned about the physical safety of their children. They are equally concerned with their psychological safety. Tragically, the fears of parents are well-grounded. Today's infants are in double jeopardy. On the one hand, they are in danger of becoming the victims of violence. On the other hand, they can become accustomed to violence, losing the ability to empathize with its victims, and taking on the role of the aggressor.

No one likes to think about violence and very young children. We are sickened by descriptions of babies who are victims of violence. We even have difficulty thinking about infants and toddlers as witnesses to violence. We would like to persuade ourselves that children under three don't understand or won't remember what they see, hear, and feel.

But because infants and toddlers **do** experience violence (and do try to understand it, and do remember it), we **must** pay attention to their experience. We must learn to comprehend the **meaning** of violence for infants and toddlers, especially since they don't yet have language to help them organize their experience and express their feelings. Unfortunately, there is no way to immunize infants and toddlers against the plague of violence that is devastating our nation. But there are ways to protect children, to heal them, to nourish the resilience of childhood, to keep hope alive.

This publication is a contribution to the development of caretaking strategies to help young victims of violence, and to provide support for those who are helping the victims. It has been created by **ZERO TO THREE**'s Study Group on Violence, which began examining the impact of violence on very young children, their families, and practitioners in 1991. We have written *Caring for Infants and Toddlers in Violent Environments* with a threefold purpose in mind:

1. We will look at what it means to be a parent in a violent environment — the concerns and problems that parents face, the strategies they use to protect their children from physical and emotional harm, and the ways in which living in a violent environment affects parents' ability to nurture and guide their children.

2. We will address the expanded concerns of caregivers, teachers and other community helpers of young children who must continually deal with violence and infants and toddlers exposed to violence.

3. We will discuss possible interventions and treatment strategies for working with young children and families exposed to violence.

Caring for Infants and Toddlers in Violent Environments is designed to help the reader understand the specific meanings of violence for the very young child, for parents, and for individuals who work in violent environments. This publication presents what is known about the impact of early experiences of violence on development. It suggests ways to help children and adults cope successfully with their experiences of violence. It describes ways in which community institutions can become safe havens for very young children and their caregivers.

How infants and toddlers experience violence

Violence is a complex phenomenon. To understand how exposure to violence might affect the development of a very young child, we need to know about:

- the age of the child;
- the neighborhood in which the child lives;
- the amount of consistency in the child's life;
- the kind and amount of support available from caregivers;
- the child's experience of previous abuse;
- how close the child was to a violent event; and
- the child's familiarity with the victim or the perpetrator of the violence.

Researchers tend to categorize violence in terms of: 1) community violence; 2) domestic violence; and 3) physical and sexual abuse.

Community violence has reached epidemic proportions in the urban United States. The United States is the most violent country in the industrialized world. Children are exposed to this violence. Infants' relatively immature cognitive and motor abilities may "protect" them for awhile from direct awareness of some aspects of community violence. But infants and toddlers are exquisitely sensitive to their **caregivers**' fears and anxiety about exposure to violence in the neighborhood, and young children's daily experience will be shaped by adults' coping strategies.

- Violence among youth, ages 11-17 has increased 25% in the last decade (Uniform Crime Statistics, 1992).
- Homicide is the second leading cause of death among **all** 15 to 24 year olds in the United States (National Center for Health Statistics, 1993).
- In 1991, the homicide rate for black males 15 to 24 years old was 158.9/100,000 —a rate 15 times greater than that for the population as a whole, and nearly 10 times the rate for 15 to 24 year old white males. (National Center for Health Statistics, 1993)
- National data document a greater than three-fold increase in homicide rates among 15 to 24 year olds from 1950 (6.3/100,000) to 1990 (19.9/100,000). (National Center for Health Statistics, 1992)
- A recent survey at Boston City Hospital found that one of every 10 children under the age of six attending the Pediatric Clinic had witnessed a shooting or stabbing. Half of these incidents occurred in the home and half in the street (Groves, et al., 1993).
- In a 1992 survey of 6th, 7th, 8th, and 10th grade school children, at least 30 percent reported witnessing at least one crime **daily**. Very few elementary school age children avoid some exposure to violence (Marans and Cohen, 1993).

What are some of the outcomes for children and families who experience or are exposed to violence in their communities? Let us list a few:

- Mothers teach their young children to watch TV lying flat on the floor and put them to sleep in the bathtub to avoid random bullets that might fly through the windows.
- Young children are fearful for their safety in the playgrounds and in their neighborhoods.
- In both cities and suburbs, children carry guns and knives to school in order to feel safe.
- Almost all elementary school children who live in inner-city neighborhoods have witnessed or been victimized by violence.
- Many children living in the inner cities report that they do not expect to live beyond their teen years.
- Parents report feeling helpless and hopeless about the constant violence in their neighborhoods.

Violence in the home is likely to be even more problematic for infants because of its literal and psychological proximity. Infants who live in violent neighborhoods are also likely to witness domestic violence (Osofsky et al., 1993). But it is important to remember that violence in the home is an "equal opportunity phenomenon," occurring in all economic, class, and ethnic groups. Domestic violence is associated with the maltreatment of infants. Strauss (1983) reported that mothers who were abused by their male partners had higher rates of child abuse than non-battered women.

- Although there are no reliable data describing the extent to which very young children are witnesses to domestic violence, available statistics indicate that 20 percent of adult women (as many as 15 million) have experienced physical abuse at least once by a male partner (Stark & Flitcraft, 1991).
- At least 3.3 million children witness parental abuse each year, including fatal assaults with guns and/or knives as well as hitting or slapping (Jaffe, Wilson &Wolfe, 1988).

Many parents have observed that infants and toddlers become distressed in the presence of an

argument. More serious forms of domestic violence are even more ominous in their consequences for infant development. There have been several case reports of two- to four-year-old children (Bergen, 1958; Pruett, 1979; Schetky, 1978; Zeanah & Burk, 1984) who witnessed parent-parent homicide. All of these case studies, although careful to note possible problems in the children prior to witnessing the murder, converge to suggest that witnessing such an event itself constitutes a catastrophic psychological trauma for the young child. The involved children developed an array of new symptoms, including reenactments of the trauma, nightmares, multiple fears, and, often, aggressive behavior.

Physical abuse is the leading cause of death among children less than one year of age in this country. Homicide accounts for 10 percent of all deaths of children between one and four years (Mrazek, 1993, citing Waller, Baker & Szocka, 1989).

- One-third of all victims of physical abuse are under one year of age. In 1990, more children under the age of one year were maltreated than in any other year to date (DHHS, 1992).
- In 1990, almost 90 percent of those children who died as a result of abuse or neglect were under age 5; 53 percent were under age 1 (Daro and McCurdy, 1990).
- One-third of all sexual abuse cases involve children under six years of age (Schmitt and Krugman, 1992).

Effects on development

The very rapid and complex changes that are part of normal development during the first three years of life influence the infant or toddler's perception and experience of violence.

- Exposure to violence affects the development of young children's thinking about themselves and the world around them, including whether relationships are trustworthy and dependable.
- Since exposure to violence affects children differently at different ages, repeated exposure to violence may lead to more significant (or severe) effects as children grow older.
- Very young children's capacities for perceiving and remembering the experience affect the appearance (or non-appearance) of symptoms related to the child's exposure to violence, the pattern of symptoms, and at what age and under what circumstances symptoms are likely to occur.

Recent research studies describe behavior or symptoms among groups of very young children who have been exposed to specific forms of violence. These findings remind us that infants and toddlers have fewer ways of expressing their feelings than even slightly older children, who use words, or play, or drawings to tell us about their specific experience. Many kinds of stress could cause a baby's difficulty sleeping or a little girl's withdrawal in her child care setting. As researchers, advocates, and policymakers, we need to understand patterns of response that are seen among many children. As parents, caregivers, and clinicians, we must be careful to pay attention to the unique experience and the meaning of that experience for every child in our care.

- Some very young children who have been maltreated demonstrate an increase in aggressive behavior. Others withdraw or become depressed. (Cicchetti & Lynch, 1993).
- Symptoms of post-traumatic stress disorder in children under the age of three years may include disrupted patterns of eating, sleeping difficulties, difficulties attending and relating, anxious reactions, fearfulness, and re-experiencing the trauma (shown by behaviors if children have not yet acquired the ability to use language) (Drell, et al, 1993).
- As with other young children raised in high psychosocial risk environments, very young children who experience urban violence may withdraw, appear depressed, have difficulty paying attention, or become aggressive (Osofsky, 1993).
- Exposure to parental fighting leads to more aggressive behaviors in boys and more withdrawal in girls. Further, children who have been exposed to more anger (and a history of abuse) show increased negative and aggressive reactions (Cummings et al, 1991; 1992; 1993).

The role of caregivers

Knowing that very young children who have been exposed to violence are likely to respond with behavior that is both troubled and troubling, we must think carefully about the role of the adults who are caring for these children: parents, relatives, friends, child care providers, ministers, nurses, social workers, family advocates, and health care workers. What is it like, day after day, to address the needs of such children and their families? Who will care for the caregivers?

In the next three sections of this publication, we will consider:

1. The experiences and roles of parents living in violent environments;

2. Community issues, from the perspective of front-line service providers and of community systems that might work together to meet the needs of children and families; and

3. Intervention and treatment issues — What problems and/or disorders can be expected to result from infants' and toddlers' exposure to violence, what types of interventions work, and what treatment strategies will be most effective in working with the youngest of victims?

Each of these three sections includes the stories of individual families whose infants and young children have been affected by violence in the home and/or community, or by physical abuse. These examples come from researchers, and from violence prevention and treatment programs across the country. Although names and identifying details have been changed, the stories, and the actual words, of individual parents, community caregivers, mental health workers, and children are real. They command our attention.

The final section of *Caring for Infants and Toddlers in Violent Environments* includes the Call for Violence Prevention and Intervention on Behalf of Very Young Children, issued in the spring of 1993 by the **ZERO TO THREE** Violence Study Group. We call for:

- a family-centered approach to addressing the trauma of violence and working towards a future without violence;
- a campaign to change our national attitudes toward violence and our tolerance of violent behavior; and
- informed, comprehensive public policy at all levels of government designed to reduce and prevent violence.

Our work is just beginning. We invite every reader of *Caring for Infants and Toddlers in Violent Environments* to join with us — to address the hurt that violence inflicts on our youngest children, and to move, for their sake and ours, toward healing, and toward hope.

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The hiding game

It is night, and I hate to find myself in this neighborhood, even in the car. But there is no reasonable other route to my house. Driving along the main thoroughfare of this area, I need to be aware of any threatening or unusual movements among the groups of people who line the sidewalks. Violence may break out between them at any moment — the result of a minor disagreement or an insult. As I drive, I need to scan the street and sidewalks. This frightens me.

I have two sons — David, three years old, and Timothy, 10 months. Driving in this neighborhood is especially frightening when they are in the car with me.

Here are the rules of the hiding game: When I say, "It's time to play the hiding game," David unfastens his seat belt and curls up on the floor of the car, between the front and back seats. (In this neighborhood, David is more likely to be the victim of a stray bullet than a car accident.) Timothy is too young to understand "games" and "rules," but he always puts his head down on the shelf of the car seat to keep an eye on David when he is on the floor.

The hiding game probably helps me more than it helps my children. It makes me feel that they are safer, and with their heads down, they cannot see the fear and wariness in my face. It's a good game, because it does not seem to scare the baby or make him cry. But the game isn't working so well any more for the three-year-old. As I turn onto the main thoroughfare and announce that it is time to play the hiding game, David immediately begins asking questions. The pervasiveness of violence in our community is not lost on him. When I told him not long ago that an elderly friend of our family had died, he responded, "Who shot her?" It is a struggle to bring up calm, secure, fearless children in a violent community.

Beverly Roberson Jackson, Ed.D.

1. PARENTING IN VIOLENT ENVIRONMENTS

Joy D. Osofsky, Ph.D. and Beverly Roberson Jackson, Ed.D.

It is a struggle to bring up calm, secure, fearless children in a violent community. And today, families are engaged in this struggle in every region of the United States and in every type of community — urban, suburban and rural. The 1991 National Survey of Children and Parents sponsored by the National Commission on children reported that parents worry a great deal about their inability to protect their children from violence and keep them safe even in their own neighborhoods. Not surprisingly, low-income and minority parents reported the greatest worries.

Protecting children is a family's most basic function. Regardless of their composition, families are uniquely structured to provide the attention, nurturing and safety that children need to grow and develop. An important psychological aspect of parenting an infant or toddler is being able to provide what has been called a "holding environment" — space in which parents can protect a child from danger and allow some measure of independence.

When danger threatens, families naturally form a wall of protection around their most vulnerable members — the children. When a child is in imminent danger, a parent may experience a rush of adrenalin that makes heroic activity possible — dashing to snatch a toddler from the path of a car, protecting a baby from gunfire with his or her own body. This instinct to protect a child is a stress response — essential, like other stress responses, in a crisis, but not healthy for daily life. Yet for families who are constantly exposed to violence, the stress is relentless. When families are also challenged, simultaneously and continuously, by poverty, unemployment, inadequate housing or family instability as well as exposure to violence, the stress can be overwhelming and lead to a deterioration of basic coping skills.

What are the psychological effects on parents of living with violence?

Parents who are aware that they might not be able to protect their own children from violence are likely to feel frustrated and helpless. They may feel powerless in relation to the constant barrage of violence in the media and apparent tolerance for violence in the society at large. They may have specific fears for their own physical safety, as well as that of their children.

When parents witness violence or are themselves victims of violence, they are likely to have difficulty being emotionally available, sensitive, and responsive to their children. Parents must cope with their own trauma before they are able to deal with their children's needs. When parents are living in constant fear, their children often lack the sense of basic trust and security that is the foundation of healthy emotional development.

Every parent faced with violence must find some way of coping to survive. The "hiding game" described above worked, for awhile, for one of us and her children (BRJ). Other coping strategies, while understandable as ways of relieving immediate anxiety, may distort parent-child relationships:

- If both a parent and infant have been traumatized by exposure to violence, the parent may have difficulty recognizing and attending to the child's distress precisely because it serves as a reminder of exactly what the adult wishes to forget.

The story of Paul

Paul is not growing up in a violent ***community****. But he is growing up in a violent* ***environment*** *— as his parents did. The legacy of pain and fear that Paul's parents inherited will be passed on to Paul and to his children s children, unless healing can occur.*

Mr. and Mrs. D were convinced that their 28-month-old son Paul was aggressive, powerful, and uncontrollable. They called him a "little demon." What they could not see was that Paul, like many reckless young children, was also a fearful little boy. The D's were frightened of their son, and perceived his night terrors, difficulty in going to sleep, and fitful crying on separation as cunning efforts to keep his parents under his control. "He is just pretending," they would say. "He is afraid of nothing. He is just trying to fool us into doing what he wants." The D's had become so angry at their son that they had no empathy with his plight. Mrs. D had little patience for any behavior that might be construed as dependent or needy. When Paul became alarmed by a fire truck and clung to her skirt, she laughed and told him he was being silly. When he cried as she left him in a toddler play group, she said, "You have no right to cry. You are always running away from me. See if you like it when I do it to you." When Paul cut himself on a piece of glass he had broken, she told him, "It is your own fault for being so destructive.

Mr. D, although less active than his wife in Paul's life, followed a similar pattern. He encouraged Paul to be "strong" and was critical of him when he was frightened or hurt. In addition, Mr. D tended to spank Paul quite hard to keep him in line. Paul had begun to hit him back, which alternatively amused and enraged his father. When he was amused, Mr. D laughed appreciatively at his son's feistiness and said, "You are tough like your old man." This approval reinforced Paul's readiness to use aggression to fight back. But when his father was not in the mood for such feistiness, he became enraged and hit the child even harder to "show Paul who is the boss." At these times Paul collapsed in tears and was then sent to his room, where he screamed in protest for as long as 40 minutes at a time.

These exchanges with his parents gave Paul the message that he was on his own. He had no secure base to which he could turn when he felt fearful or needy. His father could not help Paul modulate his anger because Mr. D could not control his own. His mother disliked any show of weakness and encouraged him to be independent, but she also scolded him for the often disastrous results of his efforts to "stand on his own."

Mr. and Mrs. D misinterpreted Paul's high activity level as a sign of defiance that needed to be punished. They also mistook Paul's efforts at physical closeness or proximity as symptoms of dependence, and dependence was not acceptable to them — even in a two-year-old.

Thoughts and feelings that are unacceptable to the parents can easily become unacceptable to their child. From this perspective, we can understand Paul's recklessness and darting away as an effort to counteract his wish to come close, which he knew would be rebuffed by his parents.

Children like Paul are asking: "How far do I need to go before mom will bring me back? How much danger is too much so that dad will protect me? How scared do I need to be for mom and dad to help me feel safe?"

Mr. and Mrs. D had to struggle long and hard before they could understand the urgent reality of Paul's fears, and before they could respond to his recklessness as a cry for help. In the process of learning to know their child, they had to remember their own fears and longings as little children who were punished too harshly and expected to do too much too soon.

The repetition of a painful past in a painful present is often at work when parents are at a loss to protect their child. When the D's were helped to reexperience their own early, unheeded wished to feel protected and secure, they became able to understand their child's fears better. Then they could begin responding to Paul's call for help. For example, they held their son when he clung to them and said: "You are O.K. I will take care of you" instead of pushing him away. They retrieved him when he darted off in unfamiliar places and told him: "I get scared when you run away. I don't want you to get hurt." They helped him when he asked for help. As the child began to heal from his anxieties through these loving ministrations, the parents found that through experiencing empathy with their child they were also beginning to heal themselves of the wounds left by their own harsh childhoods.

Alicia Lieberman, Ph.D.

(adapted with permission from Lieberman, AF.1993. *The Emotional Life of the Toddler.* New York: The Free Press)

- Parents may become overprotective, hardly allowing their children out of their sight.
- Parents, particularly those who were abused or deprived of adequate nurturing during their own childhoods, may turn to their young children for excessive support and then become angry at them for not fulfilling the parent's needs.

A single violent event is difficult enough for parents to deal with. A chronically violent environment produces chronic, unrelieved stress. Many parents who live in violent environments are burdened even further by the lingering effects of violence they have experienced in the past, as children who were abused emotionally, physically, or sexually. Unless these parents are somehow helped to remember their own fears and longings as little children who were punished too harshly and expected to do too much too soon, they may repeat their painful past in the present, with their own young children.

What is it like for infants to be raised by a stressed and depressed parent?

Parents who live in environments that include poverty and stress are more likely than other parents to experience symptoms of depression, including feelings of sadness, hopelessness, and helplessness; disturbances in sleep and appetite; and chronic exhaustion that goes beyond the fatigue that tends to "come with the territory" of caring for an infant or toddler.

Parents who are extremely depressed may be unable to provide for their young children's most basic physical needs. Many depressed parents, however, use all the energy they can muster to care for their children. But in spite of these parents' conscious efforts, their depression may interfere with some of the specific kinds of nurturing that very young children need. For example:

- People who are depressed look sad and anxious. But babies come into the world prepared to respond to smiles and lively facial expressions. If they don't find these in their caregiving environment, babies begin to withdraw from the human world. Soon their sad, blank faces reveal their own depression.
- People who are depressed tend to talk less often and with less intensity. They are less likely to look at the person they are talking to and respond more slowly. But babies respond best to warm, loving, animated voices — the "baby talk" or "motherese" that is a part of every culture.
- People who are depressed tend to be hostile and irritable, especially in intimate relationships. They may be passive and unresponsive or negative and critical. They have difficulty controlling their emotions. They drive other people away. A young child whose depressed, isolated parent rarely hugs, smiles, and praises — but often scolds and shouts — grows up to believe he or she **is** "bad" or "nasty" and deserving of punishment. Who has told the child anything different?

Supporting and building resilience in families

Some families manage to nurture their children well despite poverty, dangerous community environments, and other adverse circumstances. Robert Hill of Morgan State University has identified five factors that have proven effective in enabling families to survive and maintain healthy relationships (Hill, 1972). He has observed their validity through more than 20 years of changing family and community demographics. These factors are:

1. Strong kinship bonds
2. Flexibility of family roles
3. Strong spiritual/religious orientation
4. Strong work orientation
5. High achievement orientation

After conducting an in-depth review of numerous studies in high-risk communities, Dr. Hill concluded that where these factors were present, families and individuals within families succeeded. Where they were absent, the family was at great risk of failure, disruption, and loss of life (Hill, et al. 1993).

How can factors that contribute to family resilience be supported and strengthened in families who are living in violent environments? Common sense (and research on family development) tell us that **every** family needs support, particularly in the stressful years of caring for infants and toddlers. Traditionally, support comes from grandparents, extended family, friends and neighbors, the religious community, and the basic human love for small children that makes even the stingiest shopkeeper in the neighborhood offer a baby a cookie. But when violence pervades a community, these traditional supports to a young family are themselves overwhelmed by stress — preoccupied with their own survival, or with caring for people in crises of grief and loss.

Individual parents who are living in violent

Barbara and John

Barbara, a young mother, and her 27-month-old son John live in a three-room apartment in a cinder-block building. The circumstances of Barbara's life seem daunting. Her husband has been in prison for most of their marriage. She must travel for four hours by bus to visit him each month. The neighborhood around her apartment is the scene of frequent violent incidents. Many of her neighbors regard police officers as an occupying force rather than as protectors of the peace.

Amidst chronic violence, stress, and trauma, John is thriving. He is bright and cheerful. His mother is not depressed or defeated. She is lively and full of energy and enthusiasm. She has a picture of her husband on display which John holds proudly as Barbara reads him the latest letter from his father.

Barbara's family — sisters, brothers, and parents — live nearby. They provide emotional support, as do other members of her community. In addition, Barbara gains strength from her intense, enduring belief in a better future. She sees the present situation — horrible as it is — as transitional. She looks forward to the day when her husband will return home and when her neighborhood will become a true community.

Barbara has come to see political change as an essential factor in achieving her vision of a better future. Her conviction gives meaning to the conditions she faces, and her enthusiasm displaces depression. Her politics, expressed initially through participation in a welfare rights demonstration and more recently in leadership of a community voter registration drive, provide a foundation of resilience for Barbara and John. She, and the political movement in which she is an active participant, are seeking to change the conditions in her community.

Discussion:

I think that belief in a better future is an important feature of resilience in adults who care for young children amidst chronic violence. Parents who are "models of resilience" are those who are available with reassurance and encouragement during adversity, helping their children understand and process stress and trauma.

This steadfastness may arise from religious belief, spirituality, ideological allegiances, and political commitment, all of which can contribute to resilience. Such belief systems give substance and meaning to dangerous events and sustain the ability to function under extreme conditions. Parents' strong religious or political beliefs can bring stability and meaning to children's lives which seem impervious to hardship and stress. Engaging in religious and/or political activities can enhance active coping.

In violent environments all over the world, there are some children who seem to remain free of psychological disturbance. As they grow older, these children see themselves as neither victims nor avengers, but as builders of sturdy, non-violent, assertive communities. In my experience, the parents of these children have strong political and/or religious beliefs, avail themselves of social support, strongly believe in their ability to control their lives, and actively try to change traumatic situations.

James Garbarino, Ph.D.

environments will continue to draw on all their emotional, material, and spiritual strength to protect and nurture their own young children and the children who are close to them. Some people in any community feel a responsibility to **all** of the children in the community — these are the grandmothers, the retirees, the good listeners of any age who work every day in quiet ways to keep neighborhoods safe for children and families and to be emotionally available to parents under stress. In addition, individuals and communities are creating programs to support and strengthen families who are living in violent environments, to reduce the current level of violence, and to prevent violence in the future. These approaches are discussed in Part Two of this publication, "Infants, Toddlers and Violence: Developing a Community Response."

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Three coping strategies for parents living in violent environments

As a parent who lives in a very violent community, I struggle to rear mentally healthy children in the midst of chaos. I have adopted three coping strategies to help me meet this challenge:

1. *Personal self-empowerment;*
2. *Protecting my children from violence; and*
3. *Staying angry.*

Self-empowerment: *In our community, violence began to escalate in the late 1980s. When I realized that the killings in my neighborhood were* ***not*** *all drug-related, I became extremely fearful — most of us, I think, are most fearful of random violence. At the same time, I knew that if I were always afraid, I couldn't function as a parent. I knew that my own fear would affect my small children. I decided to take action. First, I tried to understand my own personal reactions to and feelings about violence. I asked myself:*

- *What do I fear most about possible violence?*
- *Is there anything that I* ***like*** *about the violence in our community?*
- *How, and under what circumstances, can I control my fear?*
- *How can I take control of the situation, for my family and myself?*

As I asked myself these questions and answered them, I found that I could use my intelligence, powers of observation, and common sense to protect myself and my children. I became a much more alert observer of my surroundings and began to notice, for example, that police officers were often posted at the four corners of the park where my children played. Through news reports and from neighbors, I learned that the police assumed these positions when violent suspects were in the area or whenever a violent incident had occurred within a mile of the park. I still take my children to the playground, but whenever police officers appear at the four corners of the park, we go home.

Protecting my children from violence*: My growing sensitivity to clues that signalled possible impending violence in the neighborhood helped me to take steps to protect my children, in the community and at home. When a child riding in a car was hit by a stray bullet (this happened a block from the home of our infant's suburban family day care provider, not in our own neighborhood), my husband and I devised ways of shielding our children in the car. (The "hiding game," described above, was one strategy.*

We also needed to protect our children at home. A few of the windows of our house face a major thoroughfare. We decided to make some rules forbidding our two young sons to look out of these windows. The boys were too young to understand the reason for these rules when we made them, so we enforced them the same way we would enforce any other household rule with a young child: We planned most family activities away from the windows facing the street. We and the children used other windows in the house to look from, and we consistently warned the boys away from the street-side windows.

We don't fool ourselves. We know that we are not totally safe. But just as we used outlet covers and stair gates to protect our young children from injury in a house that is blessed with electricity and a staircase, we have taken steps to protect them from harm in a house that is threatened by violence.

Staying angry: *Maybe I would be more comfortable if I could ignore the violence in my community, or perhaps accept it as a part of life. But I decided that I could not let myself forget that violence is awful —* ***every*** *time it occurs. I realized that if I wanted to fight violence, I could not tolerate it, or become immunized against its effects, or let my children accept the violence around them. I couldn't become angry about violence "only" when it affected a family member or a small child or a neighbor. I couldn't let my children begin to think that violence is an acceptable human response to frustration or conflict.*

Tolerating violence feeds violence. When people in my neighborhood thought that violence occurred only among drug dealers, they were complacent. When they realized that anyone in our community could become a victim of violence, they became fearful. I believe that I have to be concerned about ***all*** *victims of violence; narrowing my concern endangers my family. We are all in this together. We must stay angry at violence, and we must channel our anger constructively in order to make the future truly safe for our children.*

Beverly Roberson Jackson, Ed.D.

Helping Young Children Channel Their Aggressive Energies

Sally Provence, M.D.

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Ask any parent whether she wants her child to be an aggressive person and you are likely to get more than one answer. After all, aggression is associated with both approved and disapproved behavior in our minds and in our society — both with the energy and purpose that help us to actively master the challenges of life and with hurtful actions and destructive forces.

Most of us want our children to be able to take a stand for themselves when others treat them roughly. We hope that they will not start fights but if attacked will be able to cope with the attacker and not be overwhelmed. A child's learning to find a healthy balance between too much and too little aggressive behavior is probably the most difficult task of growing up.

According to developmental theory, aggressive impulses or drives are born in the human child and are a crucial aspect of the psychological lifeforce and of survival. In the course of healthy development, these drives are normally expressed in various behaviors at different ages and, with assistance from parents and others, are gradually brought under the control of the individual — moderated, channeled and regulated but by no means stamped out. We expect that young children who are developing normally will display aggressive behavior — both physical and verbal — toward adults, other children, and objects in their environment. Brothers and sisters engage in combat. Young children in groups inevitably behave aggressively toward one another just as they behave in friendly ways and join in interesting activities. When they want the same toy or the same adult, competition and strife are bound to occur. If a child is irritable or angry, he or she may lash out at another without apparent provocation.

During the first year, infants are not often thought of as behaving aggressively, and yet encounters in which an infant pushes, pulls, or exerts force against another are signs of the outwardly directed energy and assertiveness that reflect the healthy maturation of aggression. But the nine-month old who pulls your hair does not know that it might hurt — it is done in the same exuberant, playful spirit that is seen in other activities. It is only in the second year, when the child develops a better awareness of his separateness as a person — of "me" and "you" — that he can begin to understand that he is angry at someone and behave with intentional force. We do not usually talk about a child's being cruel or hostile toward others until some time during the second year. Even then, he does not know enough about cause and effect to understand the consequences of his action or how to regulate this behavior toward others. When your fifteen-month-old smashes a fragile object, he is caught up in the pleasure of assertiveness, not anticipating its result.

Parents sometimes tell me about their toddler who "knows better" than to hit or bite. They believe this is so because when he is scolded, he looks ashamed. What the toddler understands is not that he has hurt someone or destroyed something but that he has earned the disapproval of his parents. Conversely, when praised for being gentle with another, he knows and is pleased that he is approved of for that behavior at that moment. It will take time and many reminders before he can understand that not hitting or biting applies to

many situations. Young children, particularly those under three and a half or so, scarcely know their own strength. The differences between a kiss and a bite, between patting and hitting, between nudging and pushing someone down are not automatically understood and children need many reminders: e.g., "Let me show you how to pat the baby (or the family dog or Daddy's cheek)"; "Patting feels nice. Hitting can hurt"; or "Do it softly (or gently), like this."

As is true of the young child's development in other areas, there are steps and phases in the socialization of aggression, and it is worth your while to learn something about what kind of behavior to expect at various ages. If you understand what an infant or toddler or a four-year-old is capable of, you can adjust your own actions and teaching to realistic expectations and save yourself worry and frustration. You don't need the anxiety of imagining that your toddler who gets very angry and has very little control over his aggression when frustrated or upset is destined to become an angry, destructive, uncontrolled four- or ten- or twenty-year-old. On the other hand, if your four-year-old has frequent aggressive outbursts and seems not to be concerned about the effect of his aggression, or even seems to enjoy hurting others, you are correct in being worried and in seeking ways to help him toward healthier behavior.

How then do parents moderate and channel their child's aggression without stamping it out by being too severe?

While there is no exact recipe, here are twelve suggestions that may help you to provide your child with the guidance he needs.

1. Keep in mind that your child's feeling loved and affectionately cared for builds the foundation for his acceptance of the guidance you will provide as his development proceeds. This includes the regulation of aggressive behavior. Children who feel loved want to please their parents most of the time and will respond to their guidance. Putting reasonable restrictions on your child's behavior is part of loving him, just as are feeding, comforting, playing and responding to his wishes.

2. Try to figure out what triggered your child's aggressive behavior. Ask yourself what might have happened that set him off — your behavior or that of another person, or something else in the situation; perhaps he is overtired or not feeling well physically. Being rushed, abruptly handled, being denied something he wants, even being unable to do something he has tried to do with a toy or physical activity often produces feelings of frustration and anger that result in aggressive behavior: the toy gets thrown, or the child cries and strikes out or stormily says, "Mommy, I hate you." This can also occur at times when there is no readily apparent cause for the outburst.

3. Make use of what you know about your child's temperament, rhythms, preferences, and sensitivities. For example, if you know that he is irritable or ill-humored for the first hour of the day or gets very out of sorts when tired or hungry, you won't pick that time to ask a great deal in the way of control. If you know that he is likely to behave aggressively when another child comes close, you will want to be nearby to help him control that behavior. If he easily becomes "wound up" with excitement and is more aggressive at such times, you will want to help him tone down the excitement so that he can continue to play. If you know that he gets upset, angry, and aggressive when teased, you will want to give him some protection from teasing by others, especially by adults.

4. Tell your child what you want him to do or not do in a specific situation but try not to give a long lecture. Your child will be aware of your displeasure from your tone of voice as well as from what you say. It is important that you try to be clear about your disapproval. However, long lectures and dire predictions are usually counterproductive. Telling a three-year-old child that God won't love her if she hits her baby brother may frighten her, but it is unlikely to help her understand and develop her own controls. A better reason is that **you** don't want her to hit him because it hurts. That you don't like the behavior is your most effective message. It helps any young child who has earned the disapproval of a parent to be reminded that she is loved even when you don't like the behavior. And sometimes the young attacker needs as much comfort as the victim because the negative feelings that are aroused by one's own aggressive behavior.

5. When your young child is playing with other children, keep an eye on the situation but try not to hover. What begins as playful scuffling or run and chase or sharing toys can quickly move into a battle between children, and they may need a referee. However, there are times when you can let young children work things our among themselves. When you believe that none of the children

is in danger of being hurt, you may decide to see how they can settle their differences because if successful, they should be better able to manage the next situation more adequately. Age makes a difference, of course. Such solutions are often within the abilities of three- to five-year-olds, while the under-threes will need your help and protection more frequently.

6. When your child is being aggressive in ways you don't like, stop the behavior and give him something else to do. You may either suggest and help start a new activity or perhaps guide him to a place where he can discharge aggressive feelings without doing harm to himself, to anyone else, to toys, or to the family pet. For example, a corner in which there is something to punch or bang or throw at can be utilized. You can say, for example, "If you feel like hitting, go and hit your pillow (or punching bag), but you can't hit the dog (or bang the table with a hammer)." Such an opportunity not only helps the child discharge some aggressive feelings but also helps him understand that there can be a time and place provided for such actions.

7. When time permits, demonstrate how to handle a situation in which there is conflict between children. For instance, if your child is old enough, you can teach him a few words to use in order to avoid or settle a conflict. A two-year-old can be helped to hold on to a toy and say "no" or "mine" instead of always pushing or crying when another child tries to take a toy. A four-year-old can be shown how to deflect a younger brother or sister who is about to move in on his treasures. Children need specific suggestions and demonstrations from adults in order to learn that there are effective ways to handle disagreements that are more acceptable than physical attack and retaliation.

8. If your child has language skills, help him explain what he is angry about. If you are able to guess and he cannot say, do it for him, e.g., "I guess you're mad because you can't go to play with Johnny. I know how you feel, but it's too late to go today" (or whatever the reason is). Among the things children begin to learn during the early years are some of the connections between feelings, thoughts, and behavior. This learning is accomplished gradually as the child hears what is said about himself and others, and he is helped to understand that feelings and ideas lead to actions, some of which are approved and some not.

9. Ask yourself if you are sending "mixed messages" to your child about his aggressiveness. If you say "Don't hit" or "Be nice" while you are not so secretly enjoying your child's aggressive behavior toward someone else, he will be confused, and such confusions tend to make it more difficult to develop self-control.

10. Keep in mind that parents are the most important models for behavior and the creators of the family atmosphere and guidance that children need in order to use aggression in a healthy way. If social exchanges in your family include much arguing or physical fighting in the presence or hearing of your children, you can count on their picking it up. You can expect that they will imitate that behavior in their interaction with others, becoming either excessively quarrelsome or physically aggressive or becoming excessively submissive out of fear.

11. Think about the very real disadvantages of physical punishment for your child. Children often arouse anger in adults when they provoke, tease, behave stubbornly, or attack others. If your practice is to hit or physically punish your child in some other way for such behavior, you need to think very carefully about what he learns from that. Even with the best of intentions, you may be sending the wrong message. Rather than learning how to control his aggression as you want him to do, he may interpret your behavior to mean that physical force always wins out, and he may not develop other ways of settling disputes. There is the danger that he will become even more aggressive or may fail to develop the ability to cope with the ordinary pressures of social contact.

12. Your child's learning to love and live in reasonable harmony with others comes about only gradually and over many years. For you as parents there will always be ups and downs, periods when you despair of "civilizing" your child or when you will worry that he will be too timid for the rigors of the world. While living from day to day with the pleasures and frustrations of being a parent, it is also important to keep the long view in mind: there is a positive momentum to development. This forward thrust of your child's growth and development actually works in favor of his acquiring the ability to channel and productively use those aggressive energies that are a vital part of our makeup.

"My mommy didn't kill my daddy. Drugs killed my daddy": A child reared in violence and love

Seven-year-old Jade tries to talk to her paternal grandmother on the telephone. She says, "Don't be mad at Momma. My mommy didn't kill Daddy. Drugs killed my daddy. He was high. He was always hurting my mommy. Them drugs killed my daddy."

Jade is trying to make sense of her world. She is trying to understand why a beloved daddy could attack her mother so violently... and why a beloved mommy could kill her daddy.

I have known Jade (not her real name) since her birth. She is a subject in the Children at Risk: Infant Development Project (IDP), a longitudinal study of 37 African American children who live with their mothers in neighborhoods with high rates of poverty, crime, inadequate housing, transience, and neonatal mortality. The goal of the study is to describe the patterns of interaction that occur within the early natural environment of the children, what these patterns mean to the children and families, and how the patterns relate to the children's social, psychological, and cognitive developmental outcomes.

In the course of the study, we videotaped the children —first as newborns in the hospital, and then for hours at a time at systematic intervals (sometimes as short as every six weeks) over a period of ten years. We also collected information on parents' life, work, and medical histories; mothers' and children's IQ scores; diaries of off-camera activities that took place during the videotaping sessions; and audiotaped interviews. These contacts over the years give an extraordinary window on the experiences of children in their earliest years.

Jade is struggling to make sense of her world, and so are we. As we re-play the videotapes of Jade's first three years of life and review what Jade's mother has told us about her own childhood and her marriage, we are struck most of all by the ambiguity and complexity of Jade's environment. Jade is a much-loved first daughter — but her father is a habitual user of cocaine and heroin. She has stimulating and loving relationships with both parents — but these relationships are marred by the tension and constant menace of violence and drugs. Her environment swings between nurturing safety and comfort and explosions of drug use and violence. How has this inconsistency colored Jade's formative years? What are the dynamics of her developing perception, attachment, and sense of self?

Let us look at what the videotapes reveal.

Jade at two days

The videotape made in the hospital two days after Jade's birth shows her mother, Ms. P., dressed in a colorful yellow gown, leaning against her pillows nursing Jade, cooing to her, and inspecting her tiny hands. (Jade was one of only two children in the sample of 37 who were breastfed.) Ms. P. calls Jade "Pooh," an early nickname that stuck, and murmurs to her. Even when she is talking on the telephone, Ms. P.'s eyes seldom leave Jade. She continues to hold her, and kisses her newborn daughter's forehead as she talks.

Jade's first year

Mr. P., Jade's father, often appears in the videotapes made during Jade's first year. He is holding Jade, or playing with her, or watching television with Jade in the crook of his arm. "Gimme some sugar, gimme some sugar," he croons, kissing her. Later the tapes show Jade joyfully toddling toward her father when he comes into the house or into a room where she is.

The P's separate

When Jade was one year old, her parents separated. The P's relationship, which had begun when Ms. P. was 16 and Mr. P. 18, had been stormy from the beginning. When Mr. P. used drugs, he was abusive, and there were many separations. But Ms. P always went back, especially after Jade was born. Ms. P. told us: "I really didn't want my girls not knowing who they daddy is; even though I thought he was gonna kill me sometimes, my heart was in my throat."

His drug use notwithstanding, Mr. P. worked as a truck driver for the city sanitation department. As a municipal employee, he was entitled to a substantial package of fringe benefits, including mental health counseling and drug rehabilitation. When the P's were together and he was not using drugs, Mr. P. was remorseful,

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telling Ms. P. that he felt bad that she was so scared and that "I'm trying to show you I can do better."

Mr. P.'s job paid for marital counseling, and both parents attended group and individual counseling. During Jade's first six years, Mr. P. also enrolled two different times in Lifeline, a 45-day drug rehabilitation program. But after each contact with the program, he began to use again. Ms. P., who also used alcohol and "reefer" but quit "cold turkey" after her final break-up with Mr. P., told us:

"Lifeline is a good program, but you have to be really serious about getting off drugs. For (Mr. P.) it was a way of getting out of trouble. He just wanted the world off his back..He had all these court orders against him, files for divorce..other people had charges against him when he tore up their house looking for me. He would stay clean for a little while..make a paycheck..get out from under the pressure..go back to using drugs."

Ms. P. added that when Mr. P. was using, he was often violent. She said that "no one, including his parents, could do anything about him or his behavior.. Once he threw me in the car trunk, and I did not get out until some people saw my fingers sticking out of the trunk, trying to open the catch."

Jade at two

After the separation, Ms. P. and Jade moved in with Ms. P.'s grandparents. Mr. P. continued to visit. (Ms. P. stressed to us that Mr. P. was never abusive or threatening to Jade or to her sister, born when Jade was two.) A particularly compelling videotape shows Mr. P. visiting Jade, her newborn sister, and Ms. P. at the grandparents' home. Jade is beside herself, twisting, wiggling, and flirting when her father arrives. She runs around shouting, "June, June!" (Mr. P.'s childhood family nickname is June Bug), grabbing him around the legs, and jumping into his arms and lap. He responds by tossing, hugging, and tumbling her, all the while crooning, "Whatcha been doin', Pooh-Pooh? Been a good girl, huh?" Jade cries when he goes out to the car, watching him intently from the window and nearly falling headlong over the back of the chair when she sees him returning.

For two hours, Mr. P. and Jade play together — she on her father's lap when he makes telephone calls; he helping to change her diaper; both of them identifying Ernie, Big Bird and Cookie Monster in a book; watching television together, Jade in her father's lap, smoothing his beard, patting his face, and kissing his nose. When Mr. P. pays more attention to Clint Eastwood on television than to her and won't let her have a sip of his beer, Jade becomes angry. She pouts and runs away. He coaxes her back, saying, "Come here, baby. Come here, pretty."

Jade at three

When Jade is three, the P's are living together again. The video camera records Jade and her one-year-old sister "helping" their mother bake a cake to celebrate the P's wedding anniversary. Ms. P. creatively explains to Jade what an anniversary is, and Jade talks constantly about the anniversary and "my daddy" — "My daddy like this cake. Hear my daddy car coming. My daddy come soon."

Ms. P. explains that Jade's daddy is at work, and joins her in the game of anticipating his arrival. "Is Daddy's car out there? You see June? He be here soon."

It should be noted that Ms. P. is just as affectionate with Jade as Mr. P., kissing and hugging her often, or sitting with both girls in her lap reading to them. School and academic learning are important to Ms. P. (Jade later went to Head Start and has always done well in school.) The tapes show Ms. P. using flashcards to teach Jade words, reading to her, and patiently explaining difficult concepts, like Halloween masks:

"Don't be afraid of the masks, Pooh. It's just another child behind 'em. Mommy got a mask. She's behind it. You ain't scared of Mommy. All the trick-or-treaters got on, is a mask."

Jade at six

During Jade's preschool years, Ms. P. left Mr. P. several times. Sometimes she and the children went to Ms. P.'s grandparents; sometimes they went to members of Mr. P.'s own large family. Sometimes the P's reunited.

When Jade was six years old, her father pushed her mother through a second-story porch rail. She fell to the ground, breaking both arms and puncturing her spleen. She went to a shelter for battered women, applied for public assistance, and made a decision to file for divorce. Mr. P. was sentenced to prison for the attack but was allowed to work at his regular job during the day. On one occasion, in defiance of a court order, he visited his mother's house instead of going to work, found Jade and Ms. P. there, and became verbally abusive

to Ms. P.

Shortly after this encounter, and with the help of the shelter, Ms. P. secured a legal order of protection from her husband, filed for divorce, and moved into a new apartment with her two daughters. Mr. P. discovered the location of the apartment and called to say he was coming to "get" Ms. P. Ms. P., just about to sit down to supper with her daughters, escaped with the girls before Mr. P. arrived.

Three days later, Ms. P. returned to the apartment. Mr. P. had kicked in the door, thrown the telephone out of the window, turned over the refrigerator, pulled the gas stove out of the wall, and eaten the meal Ms. P. had left on the table. But he had harmed not one of his daughters' belongings.

Later, Ms. P. told us about the vow she made that day:

"I'm not running any more. I'm just tired of him jumping on me in front of my children. What do I teach them girls by running? His blood is red just like mine, and I'm not gonna let him jump on me any more. He don't pay for nothin' here. I'm tired of this man bothering me and my children. I'm going to get me a gun."

In Ms. P.'s neighborhood, this was easily accomplished. After talking to children on the street, Ms. P. bought a gun for $75 from teenage boys who were playing basketball in the playground of the neighborhood elementary school. They gave her three bullets and showed her how to fire the gun. Ms. P. recalled, "I put it in my pocket and tried to forget it. I didn't want to mess with him, but I just wasn't running any more."

Jade at seven

Ms. P. continued to fear Mr. P. She updated her court protection orders as required, by going regularly to the local police station. She also had family members accompany her in her daily comings and goings. Eight months after buying the gun, Ms.P. returned home one day after an errand; Jade, her sister, and Ms. P.'s stepfather were in the car with Ms. P. When they got out of the car, they discovered Mr. P. standing in front of the apartment house.

An angry exchange followed. Jade was screaming. Mr. P. accused Ms. P. of telling Jade that he was "high" — which he denied. Ms. P. told us what happened next:

"I said, 'Jade's not crazy. She can look at you. She know when people been smoking reefer. She know when people been drinking. She been around it all her life, so how could she not know? She know, I didn't have to tell her anything.'

He grabbed me then.. He choked me until I slid down the side of the building. I was just about unconscious. I could hear Jade sayin', "He choking her, he choking her. Call the police, call the police. June fixing to fight Mommy again."

Ms. P. heard Mr. P. say,"Man, I'm fixing to kill this bitch." She remembered the gun in her coat pocket and brought it out. She "said something to God," closed her eyes, and pulled the trigger.

When Ms. P. opened her eyes after the shot, she saw her husband on the ground, but she didn't think she had shot him:

"I didn't see no blood. I didn't see where no bullet had hit him. I figured he was just laying there, trying to dodge the bullet. So I jumped in the car and went to the police station. I knew he wouldn't hurt the kids. And the safest place for me to go was the police station. If I went to anybody else's house, he would just come after me, breaking out windows and kicking in doors. So I went to the police station."

In fact, Mr. P. had been killed instantly. And in one sense, the police station ***was*** *"the safest place" for Ms. P. The police computer records of Ms. P.'s history of court protection orders convinced the state attorney to rule her action justifiable homicide. Ms. P. was released with no criminal record against her, no hearing, and no trial.*

But Mr. P.'s large extended family, who had previously supported Ms. P. in her difficulties, now turned against her. They threatened to kill her and tried to gain custody of Jade and her sister. Ms. P. recalled:

"Jade was real scared that (Mr. P.'s family) would hurt me or I would have to go to jail. She say, 'Mommy, you don't have to go to jail, do you?'"

She continued:

"I give the girls kisses and hugs and try to make them feel safe. I don't know how she feel. I got an empty feeling. I couldn't say I was sad or guilty. I just wasn't scared anymore. I knew I had to keep it together because of the kids. The family still don't talk to us."

Jade tries to understand

The last conversation Jade heard between her parents before her father was killed was an argument about her — her father accusing her

mother of telling Jade that he was on drugs again; her mother insisting that Jade, at age seven, had the knowledge to recognize the effects of drinking and drug use on her own.

Jade has lost not only her father, but his whole family. She is trying to recapture some of what she has lost. Ms. P. tells us:

"Pooh said she called her (her paternal grandmother). She said, 'Don't be mad at Momma. She not mad at you. Them drugs is what got the best of June. My mommy didn't kill him. Drugs killed my daddy. He was high. He was always hurting my mommy. Them drugs killed my daddy.'"

Jade is seven years old, a graduate of Head Start and a high achiever in second grade. She is trying to understand why a beloved daddy could attack her mother so violently, and why a beloved mommy could kill her daddy.

How will Jade continue to function, given the inconsistency of her early world — swinging between nurturing security and explosive violence — and the loss of a beloved father? We are still looking for answers. We know that Jade's early life included a level of consistent, loving interactions that many children of any socioeconomic level do not experience. Unreserved, continuously spontaneous, joyful, enamoring relationships with both parents contributed to Jade's sense of herself a person much treasured by both parents. Her mother, in particular, loved the inquisitive side of Jade's own personality and encouraged her daughter's delight in the wonder of exploration.

Although Jade could not trust her parents with each other, she could trust them with herself. What research exists on the long-term adaptation of young children exposed to violence teaches us that the basic sense of self and security that children develop early allows them to better master traumatic experiences. The consistent, loving caregiving that Jade experienced in her earliest years may come to her aid now, and in the future.

Like Jade, we are still trying to understand the effect of her life experiences on her development. We will continue to follow her. Her story will add to understanding of the long-term adaptation of children who experience violence.

Dolores G. Norton, Ph.D.

2. INFANTS, TODDLERS AND VIOLENCE: DEVELOPING A COMMUNITY RESPONSE

J. Ronald Lally, Ed.D. and Marilyn M. Segal, Ph.D.

The subtitle of this publication is "hurt, healing, and hope." When we talk about developing a community response to an epidemic of violence, we need to consider each of these words — the immediate hurt that children, their families, and caregivers in the community are experiencing; the healing that must take place; and ways to create and sustain a sense of hope in the future. In order to be effective, we must develop an ongoing social support system that constitutes the daily fabric of community life. Linked interventions should provide a blend of protection, treatment, and prevention.

The story of Jade and her family reveals how much we must still do in order to create communities that are safe for children and families. Jade's community is by no means bereft of resources or of people who are trying to help. We see opportunities for employment, income maintenance, access to health care, including mental health services and drug rehabilitation programs, conscientious law enforcement, shelter and counseling services for women who have been abused, and involved, extended families. For reasons that are not clear to us, these supports were too few, or too late, or too fragmented to prevent or contain the violence that devastated Jade's family. It remains to be seen whether the supports that are now available to Jade, her mother, and her sister, or that become available, will allow healing to occur and hope for the future to flourish.

We live in the most violent country in the industrialized world. We also live in a country where people are resourceful, energetic, and capable of enormous efforts for the public good. Outraged by the toll that violence is exacting, communities are beginning to create violence prevention and intervention programs. As yet, few such initiatives address the specific needs of infants and young children, their families, and caregivers. We hope that this publication will encourage many such efforts to begin.

In the pages below, we look at two groups of caregivers whose work, directly or indirectly, touches the lives of all families with infants and toddlers — child care providers and police officers. These caregivers can do much to repair the frayed fabric of community life. Strategies that prove successful in training and supporting child care providers and community police officers as they address the needs of very young children who are victims of or witnesses to violence are likely to be useful, as well, to front-line health care workers, family advocates, and other community service providers.

Before turning to descriptions of the Boston-based Child Witness to Violence Project and New Haven's program on Child Development and Community Policing, let us consider the notion of a "safe haven" for very young children, and how the child care setting can provide such a sanctuary for infants and toddlers who live in violent environments.

David Hamburg, President of the Carnegie Corporation of New York, reminds us that a "safe haven" is critical for human children. Human development, unlike that of other species, involves prolonged immaturity. Human children need pro-

tected early years spent with caring adults. If children do **not** have such protection, if they do **not** feel safe and secure with trusted adults, they will develop their own strategies for achieving safety, security, and survival. But strategies developed prematurely and based on fear, rather than trust, are almost always rigid and limiting. If we wish to prepare young children to act in more caring and less violent ways, we must provide them with sanctuaries in which to explore caring and nonviolent ways of behaving.

Not surprisingly, the characteristics that identify an environment that is a safe haven for children are the same characteristics that identify a quality child care environment for infants and toddlers. By helping parents select a child care setting that is a safe haven for their infants and toddlers — and by working to increase the supply of quality child care settings, especially in high-risk communities — we can begin to build hope, as healing continues.

Indicators of quality

Indicators of quality can be described in four categories: policy and procedures, environment, caregivers, and program. Let us take a closer look at each of these indicators:

Policies and procedures

Whether or not infants and toddlers have been traumatized by violence, they need the security of having a close relationship with two or three very special people. A child care setting that invites parent participation and listens to parents' concerns protects the bonds between parent and child. A child care setting that assigns a consistent caregiver to every child and that allows the caregiver to stay with the child over several years increases the number of special people with whom the young child can form a close, reliable relationship.

The environment

All infants and toddlers need to be in an environment that is safe, well organized, and home-like. They need to have a sense of ownership in their setting, knowing where things belong and predicting where they are. They need to be in an environment that is soft and homey, with appropriate toys within their reach. They need to know when they go home at night that they will come back the next day to the same environment where everything is safe and familiar.

The caregivers

For every infant and toddler, the most important person in their child care environment is their primary caregiver. This caregiver needs to have specialized training in early childhood development and a strong affinity for young children. He or she needs to be a good reader of infant and toddler cues, capable of sustaining an ongoing dialogue that respects the pace of each child. The caregiver of infants needs to know ways of comforting and quieting the infant who is agitated, and of engaging the infant who is too often "tuned out." The caregiver of toddlers needs to recognize when to encourage autonomy and when to provide the safety and security of limits. Caregivers of all young children must be attuned to individual differences and must help each child develop a sense of competence and self worth. The love and caring of a consistent caregiver is a buffer, for a child who has been traumatized, against the impact of harsh, overwhelming realities.

The daily routine

Just as infants and toddlers need the security of a familiar environment and a consistent caregiver, they need the security and the predictability of a familiar routine. For very young infants, the routine is modulated by their own natural rhythms, with patterns of sleeping, eating, and playing differing for each infant. In the toddler years, the routine is imposed by the caregiver. Caregivers can help toddlers adjust to routines by introducing visual, musical, or word cues to signal a change in activity. A greeting song in the morning, a clean-up song that signals the end of playtime, dim lights and a story at nap-time, and a goodbye circle at the end of the day help to establish the daily routines that give children a sense of security.

The philosophy

The final criterion for a quality early care program is a philosophy expressed in action, and by example. Unquestionably, all child care center staff and family child care providers should profess a love for children, but a statement of love is not enough. In a quality program, every child and parent is valued, and the importance of caring and sharing is transmitted to every child. Children learn kind words because they hear kind words. Children learn to cooperate because they do not have to compete. Children learn to empathize because they have experienced empathy. Children learn to love and trust because they are loved and trusted.

Lessons from the Family Development Program

Those of us who work in child care settings where toddlers are taught "duck and cover" routines to

protect them against gunfire may be tempted to dismiss this description of a "child care safe haven" as unrealistic — a vision to be achieved, perhaps, in the next century. In fact, a child care program that embodied all the indicators of quality just described was offered to families twenty-five years ago, as a component of Syracuse University's comprehensive Family Development Research Program (FDRP). In this effort, designed to influence the permanent environment (the family and the home) of children born into low-education, low-income households, both parent contact and child care were essential, integrated aspects of the comprehensive, long-term intervention.

At the Children's Center, FDRP's child care setting for infants, toddlers, and preschoolers, child care staff believed that the children in the program were capable of:

1. learning something about anything in which they showed interest;

2. learning to understand that their actions and choices had an impact on others;

3. learning that cooperation and concern for the rights of others would ultimately allow them to express their own creativity, excitement, curiosity, and individuality more fully;

4. learning that wonder and exploration were encouraged by adults; and

5. imitating the actions of staff toward children and other adults.

The Family Development Research Program is one of a handful of intervention programs that included a longitudinal follow-up study. In 1987, the researchers' dramatic findings captured the attention of The Washington Post, the Los Angeles Times, and the London Times. Ten years after their participation in the FDRP, children had a 6 percent rate of juvenile delinquency compared to a 22 percent rate for children in a control group. Not only was the control-group delinquency rate almost four times greater, but the offenses were much more severe. Of the four program group children with probation records, three were charged with simple "unruliness" and the fourth with one-time juvenile delinquency. In contrast, of the 12 control-group children with criminal records, five were chronic offenders. Control group children committed acts of burglary, robbery, physical assault, and sexual assault.

When will we ever learn?

Interventions with parents and caregivers in the community: Lessons from the Child Witness to Violence Project

Betsy McAlister Groves, LICSW

A 1991 study of patients at the Pediatric Clinic of Boston City Hospital, which serves an urban, high-risk population, revealed that 10 percent of the children in the sample had witnessed a knifing or shooting by the age of six. Parents and caregivers, particularly those who live in areas with high rates of community unrest, often feel hopeless and overwhelmed by the barrage of violence in their lives. It is also increasingly common for child care providers to hear stories from even the youngest children in their care about violence they have witnessed in their homes and on the streets.

The Child Witness to Violence Project (CWVP) was founded in 1992 as a response to this growing epidemic of violence. Our mandate is to identify young children who have been exposed to violence and provide intervention to the child and family in order to ameliorate some of the negative effects of such exposure.

The key to helping children who are affected by violence, we have learned, is supporting the adults who are most important to young children — parents, child care providers, and others in the network of helpers who shape young children's lives. A description of our consultation with the staff of a child care center illustrates this model of support. The story of Melody shows the way in which a CWVP therapist worked briefly with an adolescent mother and daughter directly, but then concentrated her efforts on consulting with the mother's teen parenting program counselor. A third vignette from our program is placed in the section of this publication that addresses assessment and treatment.

Consultation with the staff of a child care center

Staff of a local child care center requested consultation on behalf of two boys, enrolled at the center, who had witnessed the murder of their mother during a burglary in their home. The father had also been injured as he attempted to intervene on behalf of his wife. The boys had gone to stay with the extended family for two weeks. The staff asked for help in planning for the children's return to the center: how to re-integrate the children into the center; how to provide appropriate therapeutic interventions for them; and how best to help other children at the center who knew about the murder. (Since the boys were older than three, the specific approaches used to help them and their classmates will not be discussed here, since they would not be developmentally appropriate for infants and toddlers. However, our approach to understanding and addressing the concerns of the adult child care staff would be similar whatever the ages of the children involved.)

Before the boys were scheduled to return to the center, a therapist from the Child Witness to Violence Project met twice with center staff. The first meeting, which occurred several days after the murder, served as a time to debrief and to formulate specific questions that would be addressed in the next session.

In the first meeting, the staff talked about loss. Caregivers expressed great sadness and vocalized their anger. The staff told the therapist that this was a family with a long history of trauma, which included the loss of many family members in Cambodia, the escape of the immediate family from the country, and several years in refugee camps. That this mother had met such a brutal, senseless, and unjustifiable death in this country seemed unthinkable to the child care staff. This family had no possessions — one of the caregivers had visited the home recently and described it as bare of furniture and toys. This staff member said, "Why would anyone want to rob this family? They had nothing."

This same staff member had gone to the mother's funeral. She described the Buddhist funeral customs in detail. The staff decided they wanted some more information about Buddhist beliefs concerning death and an afterlife, as well as mourning practices. The staff discussed the horror of the manner of the mother's death. One caregiver summed up the group's mood when she said, "I cannot bear to think about it. How am I supposed to help these children when I can't even think about it myself?"

One by one, as they struggled to cope with their sadness, the staff contributed their memories of the mother and the family. At the end of this first meeting, the group drew up a list of specific questions to discuss at the next meeting:

1. What exactly happened? What were the details of the tragedy? What did the boys see? (The teachers decided it was important to know the details so that they could answer questions or correct misperceptions the children might have.)

2. What behavior/emotional state could be expected from the children who witnessed the murder? How could the center best provide therapeutic support for these children?

3. How should the issue be addressed with other children at the center?

4. How would the staff manage their feelings of horror and grief?

At the next meeting, we addressed these questions. By talking to the police, the CWVP consultant was able to obtain more specific information about the murder, including a description of how the mother died, where the children were at the time of her death, and what happened when the police arrived at the scene.

The consultant used her knowledge of the symptoms of post-traumatic stress disorder in children to predict some of the behaviors the children would show. She predicted that the children might have difficulty focusing on tasks, might show increased need for closeness and comfort from caregivers, and might be more anxious at times of transition between daily routines. They might be hypervigilant and have exaggerated fears and anxieties.

The staff decided to tell the older children at the center who were classmates of the two boys what had happened. Giving an explanation to the older children communicated an important message: it was ok to talk about scary events; it was ok to talk about death. Even for the younger children without expressive language, staff was reminded of the importance of calming them by verbal acknowledgment of their experiences and emotional reactions.

Discussion

A critical aspect of helping young children who witness severe violence is maximizing the poten-

tial of the environment to support the children. A caregiving context that supports the children in dealing with the enormity of loss and horror helps the children's recovery.

In this consultation, the CWVP therapist strengthened child care providers' capacities to respond effectively to two traumatized young children. The first meeting gave child care center staff permission to face their own horror and grief about the situation without having to consider the children's needs. They gained some measure of control over their feelings and could then be better prepared to talk to the children. For the second meeting, the CWVP therapist gave practical information and helped the staff formulate a specific strategy for working with this issue in the center. Particular attention was paid to the developmental needs of children at the center who were preschool age and younger. Staff reported that this attention to planning helped alleviate their anxiety about the children's return to the center.

Melody

Melody, the two-year-old daughter of a 17-year-old mother, was referred to the CWVP by the outreach counselor of a teen parenting program. This counselor had worked with the family for a year and a half prior to the referral, which was made because Melody had witnessed the assault and rape of her mother by her father. The rape was brutal and terrifying, occurring in the family's three-room apartment over a six-hour period. It ended when the police broke into the apartment and caught the rapist as he was leaving on the fire escape.

A therapist from CWVP met with the mother and Melody five days after the incident. In the session, the mother described Melody as being withdrawn, "afraid of everything." She contrasted this behavior with Melody's normally outgoing, happy, and engaging disposition. The first day after the event, Melody was afraid of "big men." By the third day, her fears were more global: she was afraid of loud noises, of trucks, of balloons; she whimpered when she was near the window leading to the fire escape of the apartment; she was not sleeping well. She was unable to separate from her mother. The mother was worried about how much Melody would be able to remember of the event, and whether this would cause problems for her later in life. While being worried about her daughter, the mother also expressed frustration that Melody was so needy of attention.

The therapist described Melody as watchful, wary, and constricted during this session. She was unable to separate from her mother; she engaged in little spontaneous play. The mother gave a very brief description of the incident, to which Melody responded, "Daddy has a monster." The mother said this was a reference to an incident that had occurred six months earlier. The father had put on a Halloween mask that severely frightened Melody; mother reported that Melody had made occasional spontaneous references to this mask for the past six months. As the mother was giving a brief description of the assault, Melody reached for two small dolls. She placed one doll on top of the other; the top doll repeatedly struck the other. She said, "Daddy hit Mommy and was biting her." She then threw both dolls down and moved to another activity. That was her only direct comment about the assault. The therapist also noted a heightened startle response in the office.

The second session was with the mother alone. The therapist discussed how Melody's symptoms were a normal response to a terrifying event. The therapist stressed the importance of reassuring Melody that this would not happen again and that she and her mother were now safe. The therapist acknowledged that it was difficult for the mother to try to be emotionally available for her daughter while she was struggling with her own shock and horror at the event. It was decided that the mother would meet more frequently with her counselor from the teen parenting program, and that the counselor would actively support her through the court process. The CWVP therapist would be available as a resource for Melody and for the mother in relation to her concerns for her child. The therapist also obtained permission to consult with the teen counselor regularly about the family.

A follow-up session was held three weeks after the event. The mother reported that Melody was much improved. She was sleeping normally; she was less fearful; she was a more spontaneous and happy two-year-old. In the CWVP office, she played and used markers, making no reference to the previous visit. The mother said that she did not want to bring Melody in again but did wish to continue her work with the teen counselor. She also told the therapist that she had made arrangements to return to school. She said that she was determined to get on with her life and not allow this event to interfere with her goals. The therapist predicted that there might be times of stress in the future, especially when the case went to court. She

offered to be available at any time the mother wanted to call or come in.

Discussion

In this case, the therapist decided to make maximum use of the already existing therapeutic relationship between the mother and the teen counselor. Therefore, the primary intervention was not directly with the mother, but with the counselor, both to help her manage her own intense feelings of horror, and to give her information about post-traumatic stress reactions in young children.

The counselor had been involved with the family since Melody's birth and was deeply affected by the brutality of the assault and rape. The counselor was encouraged to talk about her feelings of helplessness and guilt that somehow she had failed to protect this young mother and her child. The counselor explored her wish to withdraw from seeing the mother as a way to avoid the horror of the situation. Nevertheless, once she recognized and acknowledged these intense reactions to the situation, the counselor was able to plan a number of concrete steps to help the mother negotiate the legal process and court procedures. She also helped the mother to work out a schedule of relief care for Melody so that she could have some time to herself. Both the counselor and the mother began to feel more in control of the situation.

The prognosis for this child and mother is hopeful. This young mother was highly attuned to her daughter's needs, reactions, and behaviors. Her descriptions of her daughter were rich with nuances of mood and affect. It is also significant that this mother is able to be forward-looking, with a strong sense that there is a future for her. She sees that she can be an agent of change and that she has the ability to direct her life. She can plan ahead and envision a future for achievement and happiness both for herself and her daughter.

Child Development and Community Policing: A Partnership between Police and Mental Health Professionals

Steven Marans, Ph.D.

In response to the increasing rates of children's exposure to community violence, the Yale Child Study Center and the New Haven Department of Police Service have developed a program that provides:

- seminars for police officers on child development and human functioning;
- clinical fellowships for supervisory officers;
- a 24-hour consultation service for children and families who have witnessed violence; and
- a weekly case conference for police and mental health professionals.

The program on Child Development and Community Policing (CD-CP) has altered the ways in which police and mental health professionals coordinate and deliver services to children and families exposed to violence.

In the first year of operation, the program has trained all 450 members of the New Haven Department of Police Service in the use of the Consultation Service and 150 officers in the seminars on child development and human functioning. Fourteen supervisory sergeants and the assistant chief of police have completed the Fellowship and continue to meet once a week with Child Study Center faculty in Case Conferences. In the first 18 months of the Consultation Service, over 300 children have been referred by officers in the field. The children we have seen have ranged in age from 2 to 17 years. Initial clinical contact has occurred from within minutes of a violent event to several days

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after. The children have been exposed to murders, stabbings, beatings, maiming by fire, death by drowning, and gunfire. They have been seen individually and as part of larger groups in their homes, at police substations, and at the Child Study Center.

Phase development, trauma, and principles of intervention

In our work with referrals from the CD-CP Consultation Service, we have been especially impressed by the extent to which the children describe the violent events they have witnessed in terms of the developmental phase-specific anxieties that are aroused. As we listen to the unfolding stories of children exposed to violence, we are able to see more clearly what constitutes the specific dangers that overwhelm the individual child. We also become able to understand what aspects and meanings of a violent event children **experience** as exceptional, overwhelming and therefore "traumatizing." All too often, adults make assumptions about the nature of a child's traumatization on the basis of the "facts" about the violence that has been witnessed. These assumptions may have very little to do with the child's experience of the event or the meaning that is attributed by the child in its aftermath.

We have found, in addition, that some adults pay little attention to learning about an individual child in order to begin to appreciate what an experience of violence might be for **this** child in the context of his or her life — and therefore, what interventions might be most useful. Greater awareness of the specificity of individual children's concerns, and the ways in which these concerns define traumatization, has direct implications for the clinical work with the child and his or her family. Such awareness should also inform immediate and follow-up strategies for intervening in the community and with those institutions involved in the lives of children and their families.

In all of our work with children who have been victims of violence or witnesses to it, we have found that it is of crucial importance to help them acknowledge and tolerate, within their developmental capacity to do so, certain realities:

1. The children were not in control.

2. The children could not predict, anticipate and plan.

3. The children were at risk of danger to their own bodies, or at risk of seeing damage to another's body, or at risk even of death.

Guidelines for response

An incident that occurred several months ago put the principles and training of the program on Child Development and Community Policing to the test. At mid-day, shots rang out. A school bus carrying eight kindergartners was caught in an exchange of gunfire between rival drug dealers. The bus was hit; one six-year-old was boy was shot in the head. The bus went immediately to a nearby middle school, where the children were met by police officers and emergency medical personnel. Officers trained in the CD-CP program were the first to greet the children. They contacted members of the Yale Consultation Service, who joined them at the school. The wounded boy was taken to the hospital. (He survived surgery, suffering some neurological impairment for which he continues to receive rehabilitative services.) Meanwhile, the police officers took the other children into the middle school; the officers began immediately to coordinate efforts to get the parents of each child to the school.

The steps that followed this immediate response, planned and executed collaboratively by CD-CP police officers and clinicians, took into account the nature of the incident, the ages of the children who witnessed the violence, their relationships to each other, and the specific worries of individual children, which were, as we have observed, closely linked to their stage of cognitive and emotional development.*

While some of the specific techniques used with children, parents, and teachers in the school bus incident would be different if infants and toddlers, rather than kindergartners, had been involved, the general principles that guided the immediate CD-CP response would be the same. These are:

1. Protect child witnesses from the excitement that follows an incident of violence — camera crews arriving, multiple police personnel, onlookers.

2. Reunite children with parents **immediately**.

*For example, a five-and-one-half-year-old girl, who had been sitting across the aisle from the classmate who was shot, exhibited persistent symptoms. Over many sessions with a CD-CP therapist, she revealed a "secret." Because she had been teasing and poking the boy who had been shot, she thought the bullet had really been meant for her, as a punishment. She thought that she might also deserve punishment for teasing her baby brother and, in fact, often wishing that he was no longer around. These "secrets" illustrate a sense of magical control not inappropriate for a five-year-old. Once the girl was able to share her worry and guilt, the therapist could help her see that she was **not** responsible for the scary events. The child's symptoms were dramatically reduced and finally resolved.

Parents are the surest source of comfort for a young child.

3. Do **not** interview child witnesses at this time. (Before CD-CP training, such interviews would have been part of standard police investigation of a violent event. Police officers now recognize that any information from young children about such an event is not likely to be immediately necessary, and that interviewing by police is likely only to re-traumatize the children, who need most of all to be with their parents.)

4. Call in the clinicians. (In the school bus incident, the CD-CP clinicians arrived on the scene within 10 minutes of the shooting.)

5. Coordinate the efforts of trained police officers and clinicians. For example, police officers who are first at the scene brief clinicians and introduce them to other authorities who may be present. In this way, the clinicians can begin to work with the child or children in an age-appropriate manner, as police officers concentrate on reuniting children with parents or other close family members.

6. See each parent or primary caregiver, provide a telephone number to call at any time with questions regarding the child's experience, and ask for permission to make contact for a follow-up assessment.

7. Coordinate and carry out appropriate responses in the broader community. Depending on the nature of the violent event, police officers and clinicians might be involved in:

- briefing groups of parents, neighbors, child care personnel, etc., giving both factual information and consultation about how to respond to children;
- making additional clinical services available;
- reducing the intrusiveness of the media;
- analyzing and influencing community responses (In the school bus shooting, for example, CD-CP officers and clinicians argued successfully that while making some adults feel less helpless, a plan to use squad cars to escort school buses the day after the shooting would only exacerbate children's concerns about safety.)

These guidelines permit an effective, sensitive response to violence that is grounded on a sophisticated understanding of both child development and the expectable complexity of adult expressions of rage and feelings of helplessness. The Child Development - Community Policing Program enables police officers to perform — and to be perceived in the community — as sources of benign authority, safety, and concern for the well-being of children and families affected by violence.

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The examples from the Child Witness to Violence Project and the Child Development and Community Policing Program provide cogent examples of how frightening the realities of violence can be, even to adult caregivers and professionals. Overwhelmed by our own personal horror and outrage, we may feel paralyzed and hopeless, or we may leap too quickly to seeing broad social objectives as the "only" effective responses to violence.

Clinicians and child development experts do have much to contribute in considering and advocating for measures that will address the variety of ills that find a common behavioral expression in violence -- the multiple sources of individual character problems and the effects of sub-standard housing, unemployment, and multi-generational poverty, which undermine development and functioning.

But it is equally important for clinicians and child development experts to use their specific expertise to help children and families directly, and to collaborate in community-based interventions. When caregivers and clinicians take the time to attend and listen, to learn about the specific meanings of a violent event from a child and his or her family, they offer a great deal. When mental health clinicians and child development experts pool their knowledge and skill with police officers, child care providers and other colleagues, their impact goes far beyond the consulting room.

The next two sections of this report address both avenues for action: assessment and treatment approaches to help individual young children cope with the effects of violence, and nationwide action to prevent violence.

Antonia: "You are crazy. You are dead."

Antonia's father suffers from post-traumatic stress disorder as a result of the torture he experienced as a political prisoner in his country of origin. Several times a week, he yells at his wife, accusing her of being a bad woman, of not loving him, and of being unfaithful. He then forces her to leave the house, sometimes in her nightgown, and demands that she knock at the door, pleading to be allowed back in. Antonia, 30 months old, shows no overt distress as she watches this scenario being played out again and again.

One night, Antonia's mother refuses to go along with this script. She does not ask to be allowed back in the house but instead, in despair, she buys rat poison, ingests it, and cuts her wrists while sitting on a park bench. A passing policeman finds her and rushes her to the hospital. There, Antonia's mother recovers and is under psychiatric observation for one week before being discharged.

On her return home, Antonia's mother discovers that Antonia has been told by the father of the suicide attempt and subsequent rescue, and the child re-enacts the parents' fight and its sequelae again and again. Looking fixedly at her mother, she says: "You are crazy. You killed yourself. You are dead." She hits her mother and on one occasion she tries to attack her with a kitchen knife.

Within a few weeks, another marital fight culminates in the police being called and handcuffing the father, who is out of control, while Antonia screams in a panic. After this episode, Antonia's mother decides to leave her husband. Mother and child move to a communal home for women in crisis, but Antonia continues to see her father during weekends. The father begins psychiatric treatment and is reported to be very compliant with treatment.

In the weeks following these events, Antonia develops multiple fears. She is terrified of the police. She stands still, listening intently, then asks: "Is that the police?" or "Is that a monster?" She stamps violently on the floor, yelling, "I kill the police!" again and again. She insists that there are scary spiders crawling on the wall, although there are none. At night she insists on sleeping in her mother's bed with her mother's arms around her. She is terrified of separations, clinging to her mother and crying loudly for a long time when she is dropped off at preschool. She refuses to let her out of her sight when they are at home. This fear of separation continues to be intermingled with violent outbursts in which Antonia hits her mother, pushes her away, and tells her that she is crazy because she "killed herself."

Treatment consists of play sessions between the child and the therapist in the mother's presence. Antonia seems to know right away what she needs to do in order to come to grips with her fears. In session after session, she plays out the different scenarios that frighten her. For example, she takes the mother doll, looks at the therapist, and says: "She killed herself," while lifting the doll high in the air and then dropping her to the floor. She then scribbles with a crayon on a piece of paper, which she gives to her mother, saying: "This is a picture to show you that I love you very much." This sequence illustrates Antonia's fear of losing her mother and her efforts to keep her alive through her love.

In another session, Antonia's ambivalent love for her father is shown clearly when the doll representing the child clings to the father doll, not wanting to say good-bye to him, but then refuses to go home with him "because a wolf lives there. If I don't go, the police don't come." Antonia is saying that she is afraid of her father's wild side and that she wants to protect herself from it. Her fear and anger towards the police (whom she probably perceives as having hurt her father) is dramatically represented in Antonia's play. In every session, she jumps on the floor in a frenzy, while repeating: "I hate the police. I kill the police." It is likely that for Antonia the police represent everything bad that has befallen her family.

Antonia's ability to use play to express and explore her most difficult feelings, together with her mother's and therapist's acceptance and support, enabled this young child to move beyond her separation anxiety and her aggressive outbursts towards her mother, and to regain the playfulness that characterized her behavior before the traumatic events she experienced. However, scars remained: she was more vigilant than most children her age to the meaning of unfamiliar noises and unexpected changes in routine, and she was more alert than most children to signs that her mother might not be feeling well. While these behaviors did not interfere with Antonia's overall progress, they serve to remind us that the effects of painful events cannot be erased, and that prevention is far preferable to having to attempt a cure. Alicia F. Lieberman, Ph.D.

3. THE ASSESSMENT AND TREATMENT OF INFANTS AND TODDLERS EXPOSED TO VIOLENCE

Charles H. Zeanah, M.D.

The current epidemic of violence in America has not spared infants. As clinicians in treatment settings begin to understand the enormity of the problem (Osofsky, 1993), we must address the complex and multi-determined effects of violence on infant safety, development, and symptomatology. We know far too little about the experience of violence in infancy—about the scope of the problem, about the symptoms and disorders associated with it, and about the assessment and treatment of young children who have witnessed or become victims of violence. Nevertheless, despite our lack of knowledge, we as infant mental health clinicians will be called upon with increasing frequency to assess and treat very young children who have been exposed to violence. We hope that the following review of the symptoms and disorders that have been or might be associated with young children's exposure to violence, assessment and referral issues, and promising treatment approaches will offer beginning guidance to infant mental health clinicians and suggest areas for further research.

Symptoms, disorders, and short-term sequelae associated with violence: Post-traumatic stress symptoms and disorder

Even at this early phase of accumulating knowledge, we are finding clear associations between children's exposure to violence and post-traumatic symptoms and disorders. There are, of course, important developmental questions to be answered about when infants are capable of developing post-traumatic symptoms. Drell et al. (1993) have asserted that infants are capable of remembering events, including traumatic ones, from the first few months of life. In support of this assertion, Terr (1990) has described several examples of older children and adults who indicate various manifestations of post-traumatic symptomatology, even when the trauma occurred in the first year of life.

A consensus appears to be emerging about the nature of symptomatology associated with post-traumatic phenomena in children (Pynoos, 1990; Terr, 1990; American Psychiatric Association, in press). Central features are symptom clusters which include:

- re-experiencing the traumatic event — in infants and toddlers this occurs most often in the form of nightmares or in play that includes reference to the trauma;
- avoidance — because of their limited motor control, infants rarely exhibit this symptom; one might see, however, an infant who has been abused by a man with a beard averting his or her gaze from all men with beards and generalizing this fearful response to other situations;
- numbing of responsiveness — infants and toddlers become emotionally subdued, socially withdrawn, and/or more constricted in their play; and
- increased arousal — in infants and toddlers, this involves hypervigilance, exaggerated startle responses, or night terrors, in which a child remains asleep but behaves as if terrified.

These types of symptoms have been noted in both children and adults, and a number of them have been mentioned in case reports of young children traumatized by their exposure to violence

(Bergen, 1958; Pruett, 1979; Terr, 1990; Zeanah & Burk, 1984).

In a case reported by Zeanah & Burk (1984), a three-year-old girl who witnessed her father strangle her mother to death and then take the mother's body to a dumpster in the rear of the apartment building developed a variety of post-traumatic symptoms in the weeks following the event. She played out a scene with her foster family in which she feigned choking her foster sister and then collapsed on the floor screaming, "I'm dying! I'm dying! Call the doctor!" She also was fearful, clingy, and experienced nightmares and night terrors.

Terr (1988) has suggested that children who experience trauma before they are 28 months old are less likely than older children to have "full verbal recollection" (p. 103). Sugar (1992), however, has reported two cases of younger children who exhibited post-traumatic symptoms. A 26-month-old girl had been involved in a plane crash at age 16 months. Her family reported that she began to describe aspects of the crash immediately after the event. When she was seen for psychological evaluation ten months later, she described and enacted various aspects of the crash in her first session with the therapist. She also had startle reactions, hypervigilance,and hypersensitivity to sounds that reminded her of the trauma. Similarly, a 27-month-old boy who had been in an automobile accident three months earlier was referred for treatment because of "repetitive, emotionally-laden and inappropriate conversation about the accident" (Sugar, p. 248). The boy played and described his traumatic experience vividly during the evaluation.

Young children who have been physically and sexually abused also have been noted to develop post-traumatic symptoms, although in many of these cases the trauma may not have been a discrete event, but rather a series of events or an enduring circumstance. This distinction may be powerfully related to the clinical picture that develops in the child, although, at this point, many questions remain about how to describe the effects of a single, discrete event versus an enduring circumstance or repetitive traumatic events.

Data about the long-term adaptation of young children exposed to violence are quite limited. Terr (1990) has suggested that effects are likely to be far-reaching. Pruett (1979) reported a case of two children who witnessed their father shoot their mother and then himself. Pruett found more serious acute symptomatology and more long-term effects in the brother, who was 43 months at the time of the shooting, than in the sister, who was 27 months at the time of the shooting. This case rais-

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The W family: Locked in a cycle of reenactment

The W family were referred to the Child Witness to Violence Project (CWVP) at Boston City Hospital by the hospital's Failure to Thrive Team, who in the course of treating one child became aware that the children had witnessed repeated violence between their mother and their father. At the time of the referral, Mr. W was out of the home; Mrs. W was resolved that this arrangement would be permanent. Mrs. W was 26. The children were Peter, age 6; Lanie, age 5; Jessica, age 3; and Tommy, age 2. The domestic violence, we were told, had begun with the birth of Lanie and had been quite severe at times.

Evaluation

The two boys were the most obviously symptomatic children in the family. Peter, who was one year old when the violence began, was now, at age six, aggressive, impulsive, and performing poorly in school. His teacher described him as a child who was always tired, unfocused, and unable to complete academic tasks. In the first interview with the therapist, Peter related a series of mishaps: "A rat bit me. My cat died. He got run over by a car." Peter was afraid that Freddie Krueger (a character from a horror film) lived in his closet. He worried constantly about impending disasters. As his mother related incidents of abuse at the hands of her husband, Peter moved over to her and said, "Don't worry, Mom. I won't let anyone beat you up."

Tommy, age two, had been diagnosed as Failure to Thrive. His apparent response to the chaos of the environment was to withdraw. He was listless, showing little spontaneous curiosity about his surroundings.

Mrs. W appeared to be significantly depressed, disengaged, and unable to create any structure or routine for the children in the home. She reported that the children all had sleep difficulties. They slept in different beds

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each night. This pattern reflected both the chaos at home and the children's chronic fears that something would happen to them in their beds. It was hard for Mrs W to describe her children clearly in a way that would distinguish one from the other. When the CWVP therapist made a home visit as part of the evaluation, she described a dark, overcrowded apartment with few books, toys, or play materials available. The therapist noted that the mother had little energy and was under-reactive with her children.

Mrs. W told the therapist about her own history of trauma. When she was 12 years old, she witnessed her uncle shoot her aunt and then turn the gun on himself. She dates her failure in school from that time. As a young adult, Mrs. W began to drink and continues to drink episodically.

In the course of the evaluation, Mrs. W told the therapist that on weekends she frequently watches horror or "slasher" videos. She said that she felt drawn to these movies, but also terrified by them. Because she is too frightened to watch the videos alone, she gathers her children together to watch them with her. As Mrs. W talked about this experience, it became clear that she was reenacting her own childhood trauma, in a vain attempt to master the overwhelming fears she had lived with. Unfortunately, she was so desensitized that she was unaware of the effect of watching the films on the children, especially Peter and Lanie, the older two, who were terrified. As Mrs. W talked about watching the horror videos, it seemed as if she and her children were the same — all locked in a cycle of reenactment. Ironically, this activity was the only example she gave of closeness with her children.

Intervention

The therapist's first intervention was to talk to Mrs. W about why her children were so frightened and why they were not sleeping. Thus began a sensitive discussion about young children's inability to distinguish fantasy from reality. Material in the movies seemed real to them, and was, therefore, very scary. The therapist helped Mrs. W plan some different routines for bedtime and stressed the importance of stability and predictability at bedtime. The Failure to Thrive Team remained involved, with both pediatric intervention and nutritional counseling.

The CWVP therapist supported Mrs. W's resolve to end her relationship with her husband, but also acknowledged her fear of being alone. Initially, Mrs. W saw herself as a victim, helpless to effect any change in her environment. Gradually, the therapist helped her initiate plans for school and day care for her children. Mrs. W was able to secure special services for Peter. This accomplishment helped her begin to see that she could make positive things happen and could advocate successfully for her children.

Discussion

Peter, at age six, revealed the effects of having been the helpless bystander to his mother's chronic abuse for the last five years. His protective stance toward his mother in the evaluation interview sounds gallant but also reveals the impossible psychological choice he must make. He can either remain helpless and paralyzed with fear, or identify with the aggressor and begin to engage in violent behavior himself. For him, it may be better to harm than be harmed. He gives us a clue about his choice when he reassures his mother that she will not be hurt again. We wonder if Peter will become the batterer of tomorrow.

The first longer-term therapeutic challenge with this family involves addressing the history of trauma in Mrs. W's life and helping her to acknowledge and integrate her own previous experience as a witness to violence. It is sobering to realize that at least some of Mrs. W's own failures at parenting are directly linked to her history as a child witness to violence — a child who, at age 12, was presumably psychologically better able to cope with the experience than the infants and toddlers who are the focus of this publication.

The second, and related, challenge is to help Mrs. W become able to differentiate her own needs and responses from those of her children. We hope that she will be able to see her children as four individuals, each at a different stage of growth, and each with different needs and abilities.

Work with the W family reminds us of the importance of conceptualizing an intervention that addresses the parents' history of trauma. This intervention stresses a dual approach for the family: concrete work to stabilize the environment combined with laying the groundwork for longer-term psychotherapeutic work with the mother.

Betsy McAlister Groves, LICSW

es a number of questions about factors that may contribute to the outcome of a young child's experience of violence: gender, age at exposure, comprehension of danger, developmental status and functioning before exposure to violence, and available support after the event.

Most clinicians seem to agree that the nature of supports available to the child in the post-traumatic environment is likely to be crucial for facilitating adaptation (Pruett, 1979; Zeanah & Burk, 1984; Drell, Siegel & Gaensbauer, 1993; Pynoos & Eth, 1985). Terr (1990), however, has emphasized that no treatments have demonstrated efficacy, and many symptoms seem particularly recalcitrant.

Other clinical patterns associated with exposure to violence

Other patterns of symptoms, beyond post-traumatic stress disorder, are likely to be manifest in infants exposed to violence. Other disorders involving anxiety, depression, or disruptive behaviors (including extremely aggressive behavior) may develop. Some investigators have reported unusual symptom pictures — for example, toddlers living in violent families who developed incoherent aggressive outbursts and who told stories full of themes of indiscriminate aggression and violence (Osofsky, 1993; Osofsky, Hubbs-Tait, Eberhart-Wright, Culp & Ware, 1992).

In studying the effects of abuse and neglect on infants, Gaensbauer & Mrazek (1981) described four clinical patterns:

1. a developmentally and affectively retarded group, who were socially and affectively muted and dull;

2. a depressed group, who were sad and sensitive to rejection;

3. an ambivalent group, who had rapid shifts of emotions; and

4. an angry group, who were characterized by emotional intensity and low frustration tolerance, in addition to extremes of anger.

George and Main (1979) found that toddlers who had been abused interacted more aggressively with caregivers and with peers. These toddlers also reacted aggressively, rather than sympathetically, to other children's distress (Main & George, 1985). At one child care center, for example, 22-month-old Merced was dropped off by his mother and began to cry loudly as she left. Several children within earshot turned to look at Merced, but 28-month-old Devon (who had himself been beaten with a belt buckle and had witnessed his mother being stabbed, and then held for three hours at knifepoint by her boyfriend) ran over to Merced and smacked him in the head, screaming, "No! No!"

Developmental compromises

Clinicians who are called upon to work with infants and toddlers who have been exposed to violence must always keep developmental issues in mind. The pace of development in the first three years of life is so rapid, and the interrelationships among domains of development so complex, that a young child's experience of violence may reverberate, affecting the child's ability to handle expectable developmental challenges.

Drell and his colleagues (1993) have speculated about a number of possible developmental compromises. One scenario, they suggest, might begin with a young child's reduction in overall activity and engagement with the world as a response to the sensory overload produced by a terrifying experience or series of experiences. Just as an adult's coping mechanisms may be useful in dealing with the crisis of violence but may interfere with good parenting (see the section on parenting, above), a young child's mechanisms for coping with exposure to violence may interfere with the child's primary developmental task — learning. In order to interrupt such a cycle, which may contribute to the child's development of a negative self-concept, parents, caregivers, and clinicians should be alert to signs of:

- selective inattention — that is, a restriction on the amount of information that the child attends to in the external world;
- increasing cognitive rigidity — that is, limitations on how much complex information about the environment the child processes;
- reduced mastery motivation — that is, a lack of curiosity and pleasure in exploring the physical world of objects.

When we consider the possible effects on development of spending the earliest years of life in a violent environment, mental health clinicians are concerned about the same issues that worry parents and the general public the most — what are these infants and toddlers learning about human relationships? Fifty years of research (stimulated in part by the observations of young children's varying experiences of danger and separation from parents in

World War II) have taught us that children develop the sense of basic trust and security that allows them to feel free to explore and master the world through their daily experiences with parents and other important caregivers. When parents — themselves anxious, fearful, depressed, or numbed by the stress of living in a violent environment — behave unpredictably, young children tend to show patterns of disorganization in their own behavior. Infants and toddlers who are at an age usually characterized by eager exploration of the world ("refueled" by comfort and reassurance from adults) tend, in violent environments, to show fear, confusion, and inappropriate emotional responses to distress.

As the vignettes that appear in this section suggest, the distortions that occur in the relationships of infants and toddlers who are exposed to violence may represent the most damaging and far-reaching effects of their experience.

Assessment and referral to mental health treatment

Many infants and toddlers are victims of violence or witnesses to it. Yet few infants and toddlers are brought to mental health professionals for assessment of their emotional well-being or for treatment of their psychological symptoms. Several factors may account for this unfortunate discrepancy:

1. The caregivers of young children who have experienced violence have often themselves been traumatized or are grief-stricken by the violent events. As a result, they may be too preoccupied with their own issues to read and respond to the needs of the young children in their care. Indeed, recognizing and attending to infants' distress may be difficult for adults precisely because it requires facing painful memories or realities. One manifestation of the psychic numbing and avoidance that are commonly noted in traumatized adults may be an insensitivity to symptoms in a young child, which serve as inadvertent reminders of exactly what the adult wishes to forget. Unfortunately, in violent environments this pattern may affect those family members and caregivers who are closest to the child and ordinarily would be the ones to seek professional help on the child's behalf.

2. Whenever a painful experience occurs, many people will encourage "forgetting" the experience. Family members and friends who do not wish to see their loved ones distressed may attempt to stifle any remembrance of what has occurred. Groves and her colleagues at the Child Witness to Violence Project report that adults often say that young children who have been exposed to violence do not need treatment because they will not remember what happened — they are too young, they will forget. According to Schetky (1978), even many well-meaning professionals believe it is unwise to have children who have been traumatized talk about their experience because it might be "upsetting" for them.

3. When young children do experience unmistakable symptoms after witnessing or experiencing violence, their caregivers may decide that the symptoms are "natural" given what the child has experienced. In a sense, of course these caregivers are correct. But to ensure that a young child's "natural" reaction to trauma does not become a developmentally unhelpful patterned response to future experiences, caregivers need:

- information about the meaning of symptoms in young children of different ages;
- guidance and support for their own immediate and ongoing efforts to help children deal with the trauma and regain momentum toward healthy development; and
- assurance that professional evaluation and treatment will be accessible, sensitive to the needs of adults as well as the child, and beneficial. Unfortunately, given our state of understanding and the universal scarcity of infant mental health resources, these assurances are difficult to offer.

Mental health professionals who have been trained to understand the complex emotional lives of very young children are often frustrated when infants and toddlers who have experienced violence are brought to them not for assessment and treatment of their psychological suffering, but to verify allegations of abuse for legal purposes. In cases of suspected abuse, we frequently see more adult attention directed toward legal issues than toward the psychological care of the child who may have been abused.

For children who witness violence, the situation is even more extreme. Psychiatrist Carl Malmquist (1986) reported on six children who had witnessed murder. Interestingly, none had been referred to him because of concern for the child's psychological well-being; rather, a legal dispute was always the occasion for the referral. Pynoos & Eth (1985) have documented that children are witnesses to as many as one in five of all homicides in Los Angeles County. Most of these involved one of the

child's parents killing the other. But only a handful of case reports and Terr's (1988) descriptive study about young children witnessing violence are available in the professional literature.

Once a referral is made, clinicians who evaluate infants exposed to violence need to consider a number of issues in order to determine if and what kinds of interventions are appropriate for the child. These include:

1. safety and stability of current living situation — that is, is the immediate threat of further violence removed from the home? Can the caregiving adults regain trust in their neighborhood?

2. age and developmental level of the child at the time of the trauma and the assessment, with special attention to the infant's capacities for attention, anticipation, and symbolic capacities; developmental milestones, such as toileting or expressive language, may be lost temporarily.

3. quality of the pre-traumatic and current caregiving environment — is there a supportive and emotionally available caregiver who is not too grief-stricken or traumatized to read and respond to the infant's needs?

4. type of violent event or circumstances experienced by the child — for example, did the event involve physical injury to the child and/or the caregiver(s)?

5. acuteness vs. chronicity of trauma — was there a single event (witnessing homicide), a series of repetitive events (physical abuse), or an enduring circumstance (living with ongoing domestic violence)?

6. actual and psychological proximity of the violent event(s) to the child — were people to whom the child is emotionally attached involved? Did the child witness or actually experience the event(s)?

7. post-traumatic and other symptoms in child and caregivers — is there evidence of nightmares, post-traumatic or reenactment play, and/or new fears in the infant, or avoidance symptoms in the adult?

8. strengths and protective factors in the infant and infant's caregiving environment which may prove useful in promoting adaptation — for example, is the young child able to play and talk openly about the trauma? Is a caregiver able to reassure a fearful infant without being overprotective?

Treatment

We know very little about mental health treatment for infants and young children who experience violence. No studies of treatment efficacy have been conducted, nor are any likely before the nature of the symptomatology and disorders that result from violence are more carefully delineated.

But infants cannot wait for research results. As clinicians, our safest course is to stay close to what the assessment tells us about an individual infant or toddler's symptoms, strengths, and circumstances in order to design an individualized treatment approach. In our experience, certain conditions are crucial for treatment to be successful. Unfortunately, these are conditions that may not be easily obtained for many families who have experienced violence. Although violence touches everyone, its effects are most profound among those with fewest resources to cope with the impact of a violent event or to escape a community plagued by chronic violence.

No reasonable treatment for post-traumatic symptoms can occur if the danger of further trauma is a real and immediate possibility. A safe environment for infant and family is an essential precondition to successful treatment. But assuring a safe environment is not always straightforward in our contemporary urban environment. Bowlby's (1969) military metaphors that led to description of the toddler's needs for a "secure base" and a "safe haven" seem sadly — and all too literally — appropriate in the 1990's. Given that some adults who have been traumatized by violence may minimize real, continuing dangers in the environment (this subconscious psychological defense that allows soldiers in battle to continue to function is less useful for parents of small children), the clinician must take responsibility for assessing the living environment and its alternatives carefully. Often, some time must be spent on this issue before moving on to other concerns.

Having determined that the physical living environment is reasonably safe for the infant and family, the clinician should attend to the infant's caregiving environment. Two related questions are central:

1. How well is the infant or toddler's major caregiver **attending** to the child's needs? and

2. How well is the infant or toddler's major caregiver **providing** for the child's needs?

The clinician must be alert to ways in which the caregiver's symptoms of trauma or grief are affecting the caregiver-infant relationship. The clinician should watch for opportunities to improve insensitive interactions, such as stifling overprotective-

ness or misreading of the young child's cues. Lapses in monitoring the infant or toddler's activities may suggest the urgency of making the infant's needs a priority in the internal world of the caregiver. To the caregiver who is already well attuned to the child, the clinician may offer assistance in thinking through complex questions such as when and how to encourage a toddler who is exhibiting fears or developmental regressions. For these reasons, psychotherapy with toddlers in the caregiver's presence is often useful, especially if the caregiver is reluctant to explore his/her own grief or trauma.

Having attended to environmental concerns, the clinician may then turn to more direct goals of treatment. Early on, it is wise to address any cognitive distortions the infant or toddler has developed regarding the traumatic event. Drell and his colleagues(1993), following guidelines suggested by Pynoos (1990), have asserted that the essence of treatment is to help the infant re-experience the trauma and its meaning in affectively tolerable doses in the context of a safe environment. For infants less than 6 months old, they recommend desensitization approaches emphasizing concrete interactional encounters involving the specific stressor. For example, Gaensbauer (1982) reported the treatment of a four-month-old girl who had been abused by her father during feedings. Thus, feeding was the interactional event focused on in the treatment. For infants aged 6 to 12 months, they recommend desensitization emphasizing the specifics of the traumatic stimulus or context. With toddlers in the second or third year of life, they recommend allowing the child to recreate the traumatic situation through developmentally appropriate functional or symbolic play. The child who has witnessed chronic domestic violence, for example, might be given a father doll, a mother doll, and a child doll and encouraged to "make a

Cindy and Ramey: Bravado and battering

Cindy, 12 months old, lives with her mother, maternal aunt, and three-year-old cousin Ramey in a small inner-city apartment. Cindy's mother and aunt have violent relationships with their respective boyfriends, who are both involved in the drug trade. The women like to brag about beating up their boyfriends and standing up for their rights when they are being "disrespected."

This bravado notwithstanding, both women are routinely battered by their boyfriends. They accept this treatment as a fact of life.

During one session, Ramey's mother shows the therapist the facial wounds she has suffered in the last brawl: her eyes are bruised, her jaw is swollen, and she has several stitches on the lower lip and inside her mouth. She recounts that her three-year-old son tried to stop the attack by holding on to his father and yelling, "Stop it!" As he listens to the story, Ramey's eyes fill with tears. His mother comments that Ramey has not been the same since this episode. He has become silent and withdrawn, cries easily, and is afraid to be away from his mother.

A couple of weeks later, it is Cindy and her mother who become the victims of violence. Cindy's father, in a rage at the mother, breaks a window to get into the apartment. The window happens to be above Cindy's crib, and the sleeping child is awakened suddenly by flying glass, which cuts her on the cheek. Although the cut is small, it requires some stitching.

In the weeks that follow, there is a pronounced change in Cindy's behavior. Her mood is sullen and withdrawn. She no longer walks and has reverted to crawling. She has stopped babbling and seems to have forgotten the words she had already learned: "mamma," "dada," and "ball." During the day, her facial expression is frozen in an expression of wariness. At night, she wakes up several times screaming in terror.

The mother agrees matter-of-factly when the therapist asks whether Cindy might be suffering from the effects of the violence she experienced. However, the mother's next response suggests that she does not allow herself to be troubled by this realization. She goes on excitedly to describe her boyfriend's latest exploit, which consisted of throwing another girlfriend from a third-floor window for becoming too possessive of him. He now calls her (collect) from jail every day. Bobby's mother is clearly flattered. "I'm really his woman," she says.

Treatment takes place in the home, with Cindy, Ramey and their mothers present during most of the sessions. The sisters are very close and do most things together. Treatment for Cindy, Ramey and their mothers is made extremely challenging by the women's total acceptance of the violence in their lives. The

surprising aspect of this acceptance is that neither mother was maltreated as a child. Cindy's and Ramey's grandparents, who live nearby, are in fact a source of emotional support and stability.

The women readily acknowledge that it was their prior drug use that introduced them to a circle of abusive acquaintances Although they have both given up drugs as a result of their parents' pressure, the craving is still a daily part of their experience, and they seem to have remained addicted to the type of relationship that goes hand in hand with drug abuse.

One goal of treatment is to make the mothers increasingly less comfortable with the violence they have come to accept as an integral part of their lives. The therapist makes clear by her reaction that she is shocked and disturbed by the violent events the mothers describe with seeming indifference. She asks specific questions, and presses for details that help the mothers relive the actual experience. She inquires about their feelings about what happened, expresses sorrow and anger about the mothers' being hurt, and urges a search for alternative reactions or decisions that could have prevented the violence. Through her painstaking attention to what actually happened, the therapist gives the message that violence matters, that she cares, and that it is imperative to find some means of protection. Through this stance, the therapist hopes to undermine the mothers' massive denial of what is happening to them.

A similar approach is also applied in relation to the children. Ramey has begun to be aggressive towards Cindy, and this emerging pattern of abuse from an older, stronger boy towards a younger, more vulnerable girl is a worrisome reminder that children enact what they see, and that violence can easily become transmitted from generation to generation. Ramey, terrified by his father's physical abuse of his mother, is learning to master his terror by becoming like him. Cindy, accustomed to witnessing her mother being beaten up, is learning to submit to Ramey's aggression.

The therapist loses no opportunity to alert Cindy's and Ramey's mothers to what is happening between their children. She asks permission to intervene directly, speaking firmly but gently to Ramey about how "hitting is not right" and teaching Cindy to say "no!" and to go to her mother for protection. She encourages the mothers to notice the early signs that conflict is brewing and to take quick action to prevent an escalation. When she discusses the interaction between Ramey and Cindy, the therapist draws clear parallels between the children's relationship with each other and whay they see happening between the adults. Like the direct therapeutic intervention with the mothers' abuse by their boyfriends, this approach is intended to address the mothers' denial that violence is wrong and to provide explicit examples of how to curb an emerging pattern of abuse and submission to abuse in their children.

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story." They also emphasize having parents present for the sessions.

Violence for young children frequently involves loss, and dealing with loss is another important component of treatment for infants, and especially for caregivers. Most writers have suggested that the sensitivity and responsiveness of the infant's caregivers following the violent event are the most important factor in long-term outcome. If the caregiver is actively grieving or has become clinically depressed, his or her capacities to be sensitive and responsive to a young child may be significantly impaired (see the section on parenting, above).

Issues of loss reverberated through our work with a 22-month-old boy and his paternal grandmother. The child had witnessed his mother murder his father; the next day, the mother killed herself. The grandmother decided to assume responsibility for the boy and brought him to the mental health clinic for evaluation. She was grief-stricken at her son's death and not too familiar with her grandson (she had 12 children and 23 grandchildren at the time). Treatment included sessions with the boy and grandmother together and occasional sessions with the grandmother alone. Work involved both helping to resolve the boy's posttraumatic symptoms and building a relationship between the boy and his grandmother. A central part of this process was being available to the grandmother so that she could become aware of and address her own feelings of grief about her son's murder and of depletion about having been a caregiver for so many children and grandchildren.

She also needed time to recognize her fears about losing this child, as she had lost his father. When she was able to bring these fears to conscious awareness, she became better able to make an explicit commitment to her grandson.

What is the most appropriate setting for mental health treatment of infants and toddlers who have been exposed to violence? Treatment reported in the professional literature has occurred in the home (Pruett, 1979), in clinics (Zeanah & Burk, 1984) or in community settings such as homeless shelters (Valliere, in press). Each setting has advantages and drawbacks. If current trends continue, future prevention and intervention efforts on behalf of infants and families exposed to violence are likely to become based more in community settings than in hospitals or mental health clinics When therapists have a choice of setting, the place finally chosen is probably less important than the reasoning that went into selecting it as the most useful for work with a particular infant and family.

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4. CALL FOR VIOLENCE PREVENTION AND INTERVENTION ON BEHALF OF VERY YOUNG CHILDREN

The Violence Study Group, ZERO TO THREE/National Center for Clinical Infant Programs

If it takes a whole village to raise a child, it also takes a village, a town, a state and a nation to protect that child from the lasting trauma associated with the experience of violence..

The Study Group on Violence formed by **ZERO TO THREE**/National Center for Clinical Infant Programs is recommending the implementation of several initial steps that can begin to alleviate the repercussions of pervasive violence in our nation's homes, individual communities and our society as a whole. Implementation of our recommendations will require broad involvement from our society — the public and private sectors, institutions, individuals, and families. Such a broad approach is necessary for the implementation of our initial steps for a simple reason: Violence has become deeply embedded in almost all areas of our society.

It is important to note that when our Study Group began examining the impact of violence on very young children, their families, and practitioners over one year ago, we realized from the outset that there are no simple solutions to the complex issues surrounding violence. However, we believe that the steps we are recommending — if implemented — will accomplish two important things:

- help the young victims of violence overcome the horrible effects of the violence itself; and
- provide support for those who are helping the victims.

Our exploration of the problem of violence initially began as a result of a plenary session at our 1991 National Training Institute. It was here that the effects of violence on very young children, their parents and practitioners were brought into sharp focus. We found that children in communities across the country are being traumatized by random acts of violence; the traditional shelters — home, school, child care — are no longer safe havens. As a result, our Study Group began collecting and studying research and information on violence and young children. At the same time, we began consulting with violence experts from the fields of law enforcement, mental health, medicine and social science. We then held a public symposium in December 1992 to garner additional views and concerns.

Approaching the problem: Our findings

The Study Group has learned that violence in its various forms cannot be disentangled; one kind of violence cannot be reduced without addressing others. Family violence as exhibited in child and spouse abuse is not a different form of violence from the violence experienced throughout the society. Family violence, community violence and societal violence are all on a similar continuum. They have an impact on each other and frequently affect the same individuals. The attitudes that tolerate and ignore violence in the society as a whole also tolerate the violence acted out in individual communities and homes throughout the country.

Dr. James Garbarino, one of the early speakers in our public Symposium, provided a model for addressing the problem:

"For the first time we are beginning to see the experience of violence and young children as part of a social phenomenon. I would liken this to what has happened over the last 40 years in our under-

standing of injuries to children in automobiles. For a long period of time we understood injuries to young children in automobiles as being part of random accidents, senseless events that were accidental, not part of anything systematic.

Only when we began to see these events in the lives of children as part of systematic phenomena that had to do with the structure, the technology of cars, the regulations of the use of automobiles, the systematic role of alcohol, only when we began to see it as a social phenomenon did we have the capacity to move on it as a matter of social policy. We are beginning to see that the daily reports of murders and shootings and stabbing and killings are not simply senseless random acts, but a part of a cultural and social phenomenon within our society."

We believe that the cultural and social phenomenon of violence cannot be addressed in the traditional single-focus, categorical tradition of problem solving that we have used in the past. Reducing the number of children killed in automobile accidents has not been achieved through applied research in a single area of inquiry; instead, research in many sciences ranging from aerodynamics, medicine, engineering and the social sciences has been applied to the problem.

Research on how to prevent auto accident deaths did not stand alone; strong advocates using this new knowledge worked arduously with automobile manufacturers, the media, law enforcement and the courts to change behavior and priorities in decision making. We now have shoulder harness seat belts in front and rear seats, stronger laws and penalties for persons driving under the influence of alcohol, programs sponsored by the beer industry to reduce excessive drinking, media stars warning against drinking and driving, car seats for infants and toddlers, car seat loan programs sponsored by hospitals and local governments, and commercials educating about the importance of car seats for children.

Although many children continue to die as a result of auto accidents, recent trends have shown a marked decline in deaths of very young children due to auto accidents. There is still much work to be done toward changing attitudes and behavior about drinking and driving, and about using car seats and seat belts. However, the "humorous" drunks and drunken drivers weaving through the streets have all but disappeared from our television and movie screens. Tolerance for this dangerous behavior has disappeared.

Call for a multi-sector approach

ZERO TO THREE issues a call for a similar multi-sector approach to the problem of violence that surrounds us. From experts we learned that:

1. Very young children exposed to violence can be traumatized with a form of Post Traumatic Stress Syndrome (PTSD) and this trauma can have an impact on their ability to form relationships, the way they relate to others, their tolerance for violence as they grow to adulthood and their ability to learn new information.

2. Many children in the United States are continually exposed to actual violence or images of violence that increasingly desensitize them to violence against others and teach them to resolve conflict in a violent manner. They often feel that threatening violence is the only way they can be safe.

3. Parents feel powerless against the continual barrage of violence in the community, media and society in general. Violence is not only tolerated in our society, it is welcomed as entertainment.

4. All of the traditional protectors of children, parents, child care workers, teachers, and others, feel that they cannot protect children from either the real violence or the images of violence in their environment.

As clinicians and practitioners from a range of disciplines who work directly with children and families, we believe that there are areas where we can have a direct impact on the problem. However, we know that we cannot do it without support from other disciplines and sectors of society.

That is why **ZERO TO THREE** calls on political leaders, legislators, the media, law enforcement, and others in our disciplines to serve as advocates and help us pursue the following three-point agenda:

1. a family centered approach to addressing trauma/prevention

2. a realignment of values; and

3. informed comprehensive public policy strategies for reducing violence.

Following is a synopsis of each of the above agenda items.

Family centered approach to addressing trauma/prevention

We recognize that parents need help in coping with the violence around them; they need information about what to tell their children about violence;

they need skills in non-violent problem/conflict resolution.

Children exposed to violence need healing for the trauma they have experienced. Very young children exposed to violence represent a special group because they are less able to talk about their violent experiences, more apt to experience overwhelming loss, and more likely to react globally to a fearful experience, even if they fail to "remember" it in adulthood. Children of all ages need skills in non-violent problem resolution and, above all, a hope for a future without violence.

Practitioners who work with children, such as child care workers, pediatric trauma nurses, school nurses and counselors, have also been traumatized by the increasing numbers of children affected by violence and the violence around them.

As clinicians we can begin applying current knowledge on addressing post traumatic and chronic traumatic stress for children and families. We can develop materials that will help parents and practitioners acquire skills in these areas. We can also provide training materials to sensitize social service and law enforcement workers to the needs of families impacted by violence.

Realignment of values

There are many things that clinicians cannot do alone. There is a need in society for a realignment of values concerning violence. Violence and violent acts are viewed as entertainment. When our awareness was raised about the consequences of drunk driving, our society ceased to tolerate or be entertained by the "funny" drunk driver weaving through traffic. When most people began to see smoking as antisocial behavior, the numbers of adult smokers began to decline. There needs to be a campaign against violence as strong as Mothers Against Drunk Driving (MADD), or the public health campaign against smoking to change attitudes and values about violence.

Violence is not only a big city problem; drive-by shootings occur in rural areas and small towns as well. Gang violence seems to be increasing rapidly in small cities. Our society has been able to tolerate growing trends in violence with little outcry. For example —

- In 1991, 1,383 young children died (half of them under age one) from abuse and other intentional injuries in 1991.
- Guns killed 222 children under age 10 in 1990 in the United States. During the same year, only 68 people *of all ages* were killed by handguns in Canada.

As we re-evaluate our tolerance for violence we should call on ourselves and others to examine our responsibility for violence. Each person who commits a violent act is ultimately responsible for that act. The choice between violence and non-violence must be examined. What are the policies that support the choice of non-violence? Are there policies that provide incentives that support a choice of non-violence? What are the rewards in society for selecting non-violent options?

Prevailing attitudes and policies support investment in disincentives to violence. Disincentives like arrest, incarceration, etc. are expensive. There should be more investment in preventing violence. More money is invested on the federal, state and local levels in building and expanding prisons than building and expanding safe, clean and affordable housing. Can we as a nation balance our expenditures on disincentives with our investments in prevention?

In large and small communities around the country, families have begun small scale campaigns against violence. Parent and victim organizations need to come together, bringing with them their current concerns about gun laws, drug laws, etc. and confront societal attitudes about violence. Issues related to incentives for choosing a non-violent lifestyle and personal responsibility for actions need to be a part of the agenda, along with the task of changing attitudes and behavior.

We call upon our political leadership to bring these groups together with media leaders and launch a campaign to change our national attitudes toward violence and our tolerance of violent behavior.

Informed comprehensive public policy strategies for reducing violence

Finally, we call upon legislators at all levels of government to begin to develop a rational approach to addressing the impact of violence in our society.

National policy should do several things —

- It should address the crippling problem related to indiscriminate gun purchases — ensure that parents understand their responsibility in gun ownership and keep handguns and other weapons out of the hands of children.
- National policy should refine the existing fragmented services into a more goal-directed set of violence prevention and follow-up services that

will include very young children and family-centered mental health strategies. Some models include:

• Hawaii's Healthy Start Program that provides visits to all families of newborns, identifies and provides prevention services, emotional support, family crisis resolution strategies and mental health services to at-risk families. On the mainland, The National Committee for the Prevention of Child Abuse is trying to replicate this in states around the country.

• In Boston, MA, New Haven, CT, New Orleans, LA, and Washington, D.C., there are university-affiliated projects that provide resources and coordinate the work of child and family services and mental health professionals to intervene in cases where a violent crime involves a child either as victim or witness. These services are coordinated with law enforcement and special police training programs to provide community-based help and follow-up toward the reduction of the effects of long-term trauma (PTSD) on these children.

• National policy should address the amount of violence children can watch on television and in the movies. (According to *TV Guide*, a violent incident occurs every six minutes on American television.)

There is an African proverb, "It takes a whole village to raise a child." Based on that premise, our Study Group believes, "It also takes a village, a town, a state and a nation to protect that child from the lasting trauma associated with the experience of violence."

As we have stated earlier, when we began examining the impact of violence on very young children, their families and practitioners over one year ago, we realized from the outset that there are no simple solutions to the complex issues surrounding violence. However, we strongly restate our belief that we can — and must — help the young victims of violence in America and help the parents, practitioners and others who are assisting the victims in overcoming the effects of this violence.

Finally, we must re-emphasize that our entire society, from the individual, to the family, to our government and institutions, must lend a hand in providing this assistance. Violence is so deeply embedded in our society that we cannot begin to heal the wounds inflicted by violence on young children unless we take a comprehensive approach to implementing these recommendations.

ORGANIZATIONAL RESOURCES

Readers should regard the following list of organizations, agencies, and programs that are concerned in some way with violence and its impact on young children and families as only a starting point in any search for information or assistance. As a result of growing public and private concern, new groups are continually being formed and new prevention and treatment initiatives are being planned. (Regrettably, it is also true that lack of resources forces many worthwhile programs to shut down.) It is always advisable to ask any new contact for suggestions about additional sources of information or help.

American Trauma Society
8903 Presidential Parkway, #512
Upper Marlboro, MD 20772-2656
(301) 420-4189

American Youth Work Center
1751 N Street, N.W., #302
Washington, DC 20036
(202) 785-0764

Boys and Girls Club of America
771 First Avenue
New York, NY 10017
(212) 351-3900

Center To Prevent Hand Gun Violence
1225 Eye Street, NW, #1150
Washington, DC 20005
(202) 289-7319

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Atlant, GA 30341-3724

Child Witness to Violence Project
Boston City Hospital
818 Harrison Avenue
Boston, MA 02118
(617) 534-4244

Children's Bureau of Greater New Orleans
Project LAST (Loss and Survival Team)
1001 Howard Avenue, #2800
New Orleans, LA 70113
(504) 525-2366

Children's Creative Response to Conflict (CCRC)
Box 271
Nyack, NY 10960
(914) 358-4601

Children's Defense Fund
Black Community Crusade for Children
Anti-Violence Network
25 E Street, NW
Washington, DC 20001
(202) 628-8787

Congress of National Black Churches, Inc.
Project SPIRIT
600 New Hampshire Avenue, NW,
Suite 650
Washington, DC 20037-2403
(202) 333-3060

Education Development Center, Inc.
55 Chapel Street
Newton, MA 02160
(617) 969-7100

Governor's Youth Crime Prevention Program
Center for Law-Related Education
4400 Cathedral Oaks Road
Santa Barbara, CA 93160-6307

Handgun Control, Inc.
1225 Eye Street, NW, #2200
Washington, DC 20005
(202) 898-0792

Harvard School of Public Health
Injury Control Center
718 Hungtington Avenue
Boston, MA 02115
(617) 432-4345

Institute for Mental Health Initiatives
Channeling Parents' Anger and Channeling Children's Anger
4545 42nd Street, NW, #311
Washington, DC 20016
(202) 364-7111

Institute of Mental Hygiene
1440 Canal Street, #1605
New Orleans, LA 70112
(504) 566-4574

Judge Baker Children's Center
Child Assault Prevention Project
The Good Grief Program
295 Longwood Avenue
Boston, MA 02115
(617) 232-8390

Louisiana Gun Responsibility Task Force
254 Nelson Drive
Baton Rouge, LA 70808

Louisana State University Medical Center
Infant Mental Health Team at Covenant House
611 N. Rampart Street
New Orleans, LA 70112

Louisiana State University Medical Center
New Orleans Violence and Children Intervention Program
Division of Infant, Child and Adolescent Psychiatry
1542 Tulane Avenue
New Orleans, LA 70112
(504) 568-3997

Louisiana Violence Prevention Task Force
Louisiana Office of Public Health
Disability Prevention Program/Injury Control
1440 Canal Street, Suite 1600
New Orleans, LA 70112
(504) 568-2509

Loyola University
Resolving Conflict Creatively
Twomey Center — Box 12
New Orleans, LA 70118
(504) 861-5830

Minnesota Coalition for Battered Women
Skills for Violence-Free Relationships Curriculum
Physicians Plaza Building
570 Asbury, #201
St. Paul, MN 55104
(612) 646-6177

National Association of Children's Hospitals and Related Institutions
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355

National Black Child Development Institute
1023 15th Street, NW, Suite #600
Washington, DC 20005

National Coalition To Stop Gun Violence
110 Maryland Avenue
Washington, DC 20002
(202) 638-6388

National Medical Association
Community Health Project
1012 10th Street, NW
Washington, DC 20001
(202) 347-1895 x29

National Organization of Black Law Enforcement Executives
908 Pennsylvania Avenue, SE
Washington, DC 20003
(202) 546-8811

National School Safety Center
Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
(818) 377-6200

Ohio Commission on Minority Health
PECE - Positive Emotional Capacity Enhancement
77 South High Street, Suite 745
Columbus, OH 43266-0377

Save Our Sons and Daughters (SOSAD)
Clementine Barfield
24421 W. Grand Blvd.
Detroit, MI 48208
(313) 361-4200

Society for the Prevention of Violence
Social Skills Training
3109 Mayfield Road
Cleveland Heights, OH 44118
(216) 371-5545

Trilateral Committee to End Violence
Urban League of New Orleans
2051 Senate Street
New Orleans, LA 70122
(504) 283-1532

University of Washington
Providing Alternative Thinking Strategies (PATH)
Seattle, WA 98195

Yale University School of Medicine
Child Study Center
Child Development and Community Policing Program
P.O. Box 3333
230 South Frontage Road
New Haven, CT 06510-8009
(203) 785-2513

YMCA of the USA
1701 K Street, NW
Washington, DC 20006
(202) 835-9043

YWCA of the USA
624 9th Street, NW
Washington, DC 20001
(202) 638-3636

ZERO TO THREE/National Center for Clinical Infant Programs
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2000 14th Street North, #380
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